South Carolina General Assembly

Legislative Audit Council

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The State of South Carolina
General Assembly
Legislative Audit Council
A Management and Performance
Review of the South Carolina
Department of Mental Retardation
May 14, 1985

THE STATE OF SOUTH CAROLINA

GENERAL ASSEMBLY

LEGISLATIVE AUDIT COUNCIL

A MANAGEMENT AND PERFORMANCE REVIEW OF THE

SOUTH CAROLINA DEPARTMENT OF MENTAL RETARDATION

TABLE OF CONTENTS

MAJOR FINDING

The Audit Council finds that the Department of Mental Retardation has moved the State forward. Through progress made in the fulfillment of its mission and in carrying out the public policy of the State, the Department has overcome inadequacies which existed prior to its establishment.

The Governor's Interagency Council on Planning reported in 1965, two years before the Department was formed, that services for the mentally retarded in South Carolina were inadequate. The waiting list for admission contained some 1,300 names, some who had been on the list for 3 to 4.5 years. Only two centers operated to ensure comprehensive evaluations of mentally retarded children. Preschool classes were nonexistent, and special classes for the primary and intermediate mentally retarded served only 29% of the estimated 19,000 mentally retarded children in South Carolina. Shortages existed of teachers, social workers, and other related personnel, and prevention activities were sparse. Further, there were no licensed private facilities for the mentally retarded in the State. Finally, little was being done by volunteer groups and local communities, and the burden of service was being assumed by the State.

Beginning in 1968, when the Department of Mental Retardation became operational, much changed. Facilities were constructed to alleviate the overcrowding and reduce the waiting list. Construction of Pee Dee Center and the

expansion of Midlands Center had a significant impact. The use of Medicaid funds provided support to this endeavor as well as allowing the Department to begin contracting with private providers for mental retardation services. This has led to a reduction of the waiting list to 480. Of that number, only 115 await residential facilities.

Currently, both DMR and the public schools provide educational services to mentally retarded children. Also, institutional staff/client ratios approach the national average of 1.6:1.

The Department contracts with 50 providers for 90 different service contracts. These contracts provide community residences, as well as day services, both of which are alternatives to institutional placement. The State, however, continues to bear the burden of service for the mentally retarded in South Carolina.

According to national statistics, the State serves 93.1% of those receiving services while the national average is 52.8%. Nationally, private group homes serve 33.8% of the population, while in South Carolina only 9.5% are served in this setting. Nationally, there has been significant growth in the development of group residences with 1-15 residents, as well as an increase in foster homes. South Carolina has also increased the development of small group homes, opening 37 in the past five years. However, the foster care program has not been widely implemented.

The mission of the Department, as stated in the statutes, is to develop, provide, coordinate and improve services for the mentally retarded persons of South Carolina. The intent is that these individuals be afforded the opportunity to develop their respective mental, physical and social capacities to the fullest practical extent, and to live as normal, useful and productive lives as possible.

The General Assembly has dictated that the public policy of the State is:

> ...to provide, when feasible, the resources, assistance, coordination and support necessary to enable mentally retarded individuals to remain at home and within their respective communities.

Individuals are to be placed in the residential program only when no other services are available. Further, policy states that those mentally retarded persons who can, should be returned to their homes and communities after appropriate periods of special treatment and training.

Although much progress has been made in reaching stated goals, the following are some areas examined by the Audit Council where improvements can be made and for which changes are recommended:

- Clients are being continued in developmental programs that may not be appropriate to their needs. Program changes are being made by individuals rather than the interdisciplinary group; and clients are kept on the same plan even though they continue to show no progress. This situation raises a question of whether clients can reach optimal levels of achievement. Also, the most effective use of agency resources is questioned (see pp. 13-18).

- Children residing at the four regional centers of the Department may not be receiving education in the least

restrictive environment as required by federal law. According to officials of the Department, 57 (9%) of the 646 children who do not attend public schools could do so (see p. 19).

- DMR's management of client funds has resulted in a loss of revenue to the State which amounted to over $248,000 for FY 83-84. The Department has not collected all entitlements for services provided from clients' recurring income. Further, DMR has been subjective in reducing clients' personal funds accounts when accounts near the maximum amount for retaining Medicaid eligibility (see pp. 53-55).

- Some parents and guardians have failed to remit to DMR portions of the clients' recurring income for services, when the parent or guardian is the third party recipient of the checks. The Department has written off $132,000 in uncollectible bad debts arising from pre-1980 parent charges and charges for respite care (see p. 60).

- Seventy-six percent of the 50 DMR special education teachers are earning an average of 10.2% below the annualized minimum salary for public school special education teachers. This has contributed to the 27% turnover DMR experienced from 1982 to June 1984 (see p. 23).

- Adequate alternative care programs have not been provided for children. A number of children for whom community placement is more appropriate have been kept in the most restrictive institutional setting (see p. 27).

- DMR has received Medicaid cost settlements for prior years' expenditures of almost $6.4 million. This has resulted in the use of an average 2.1 million State dollars per year until the State is reimbursed by the federal government (see p. 64).

- There is a lack of accountability at one of the DMR pharmacies, and problems with uniformity among the three centers operating in-house pharmacies. Employee diversions could go undetected and the situation makes it difficult to document a client was actually administered his medication (see pp. 67-72).

- DMR pays partial living costs of some employees. Free and reduced housing is provided certain DMR employees resulting in a loss of over $9,000 per year (see p. 76).

Additionally, DMR is funding construction of community residences for lease to private non-profit vendors. Some funds used for construction are surplus client fees from institutionalized clients who may never qualify for community placement.

The Council's review of alleged abuse cases and their investigations showed questionable determination in some cases. Also there are cases of conflicts of interest in the appointment of investigations and evidence at one region that cases are not formally investigated in a timely manner.

The Audit Council appreciates the high degree of cooperation and support shown by the Department during the course of the audit.

The following chapters in this report outline in detail problems in the areas of client services and finance and administration.

CHAPTER I

HISTORY AND ORGANIZATION

Introduction and History

The State began providing mental retardation services in 1917 when the General Assembly created the State Training School for the Feeble-Minded at Clinton. The school opened in 1920, and operated under the Department of Mental Health (DMH) until 1957. Also, Pineland State Training School near Columbia, which opened in 1956, was operated by the State Department of Mental Health. A third residential center at Ladson, the South Carolina Children's Habilitation Center, was created in 1963 and operated under a separate board.

Along with DMH services, in 1952 the General Assembly authorized the State Department of Education to operate programs for mentally retarded children. During the early 1960s, funds were appropriated to the State Department of Vocational Rehabilitation earmarked for services to mentally retarded persons.

In 1967, mental retardation services were consolidated under the South Carolina Department of Mental Retardation (DMR). Act 228 established DMR as the first separate department of its kind in the United States. In July 1968, all powers and duties of the boards of trustees for Whitten Village, Coastal Center and the South Carolina Department of Mental Health, relative to mentally retarded services, were transferred to and vested in the State Department of Mental

Retardation. Additionally, in 1972 a fourth residential center, the Pee Dee Center at Florence, was opened.

On July 1, 1968, when the Department became operational, there were 3,700 residents in its three centers and almost 1,300* people awaiting admission. As of June 30, 1984 there were 2,740 residents in DMR's four centers, 684 residents in community facilities, and 480 people awaited admission to DMR programs and facilities (see Table 1).

TABLE 1

DMR CLIENTS BY PLACEMENT

JUNE 30, 1984

Placement	Number of Clients
Residential Services	
Regional Centers	2,740
DMR Operated Community Residences	181
Provider Operated Residences	
ICF/MR Community Residences	120
Boarding Homes	291
Supervised Apartment Living	48
Nursing Home Placements	41
Home Care Placements	3
Total Residential Enrollment	3,424
Community Day Programs	
Children's Programs	756
Adult Programs	2,650
Total Community Day Programs Enrollment	3,406
Other Services	
Summer Services	2,706
Residential Respite Care	450
Family Care Program	19
Follow-Along Caseworker Supervision	774
Diagnosis & Evaluation	1,044
Court Evaluation	30
Genetic Services - Clinical Evaluations	1,737
Total Other Services	6,760[1]
TOTAL DMR SERVICES & ENROLLMENT	13,590[1]

[1]Number reflects duplicate counts for clients receiving multiple DMR services.

Source: DMR Five-Year Plan

*The 1968 waiting list was a registry of those who requested services from DMR and whose eligibility had not been established through diagnosis and evaluation. The 1984 waiting list represents only those who have been found eligible for services through diagnosis and evaluation.

Organization

The South Carolina Mental Retardation Commission, the Department's seven-member governing body, has jurisdiction over all public institutions within the State for mentally retarded persons. The Commission is composed of one member from each Congressional District and one member from the State-at-large. The Commission determines policy and adopts necessary rules and regulations governing the operation of the Department and the employment of professional staff and personnel.

The South Carolina Code of Laws authorizes County Mental Retardation Boards. Their purpose is to develop, provide and coordinate community services for the mentally retarded. Nineteen county or multi-county boards have been developed and serve 24 of the 46 counties.

The State Commissioner for Mental Retardation is the Department's chief administrator. Appointed by the Commission, he has jurisdiction over the Department's residential centers and administers a statewide network of community services and programs. The Department's Central Administration Office is located in Columbia (see Table 2).

For administrative purposes, the Department divides the State into four service regions. Programs within each region are supervised by the Superintendent of the respective regional center (see p. 11).

In FY 83-84, State appropriations provided 57.9%, federal funds 2.6%, Medicaid funds 38.4% and "other" funds

1.1% of total system-wide revenues. "Other" funds are those received from canteen sales, sale of surplus equipment, USDA Nutrition Program, work activity centers, and other similar sources.

Table 3 provides a breakdown of DMR revenues and expenditures from FY 79-80 through FY 83-84. Over the five years, State revenues increased 26%, federal funds decreased 48%, Medicaid funds increased 51% and other funds increased 24%.

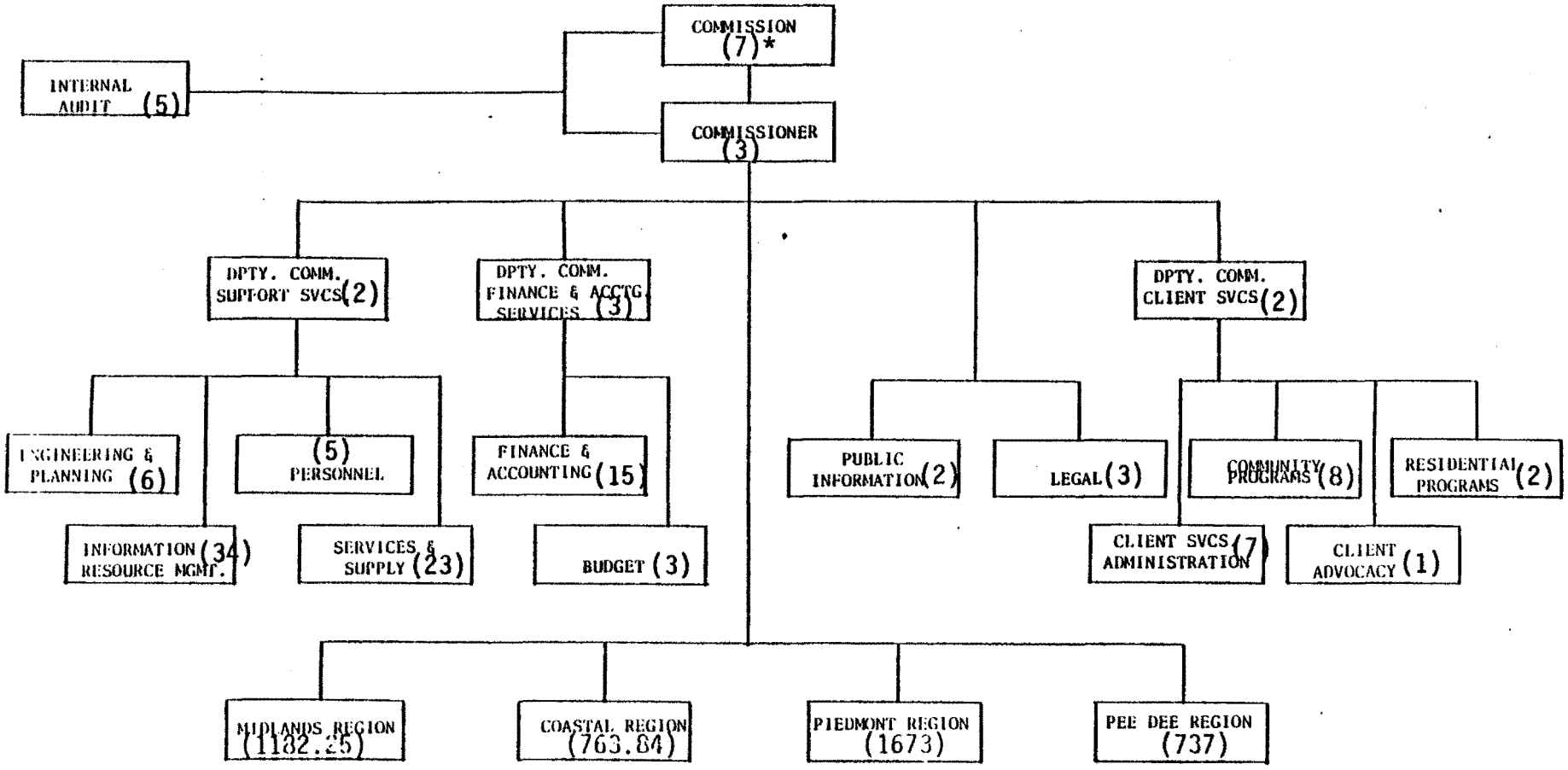
Expenditures by function for DMR increased (decreased) from FY 79-80 through FY 83-84 as follows:

Administrative	35%
Services Support	25%
Developmental	(3%)
Health	42%
Community	74%
Residential	15%
Prevention & Research	27%

Overall, DMR revenues and expenditures increased 29% while the total number of personnel decreased by 7% from FY 79-80 through FY 83-84.

TABLE 2

SOUTH CAROLINA DEPARTMENT OF MENTAL RETARDATION



*Number of personnel if more than one.

Source: DMR five-year plan for services: 1985-1989.

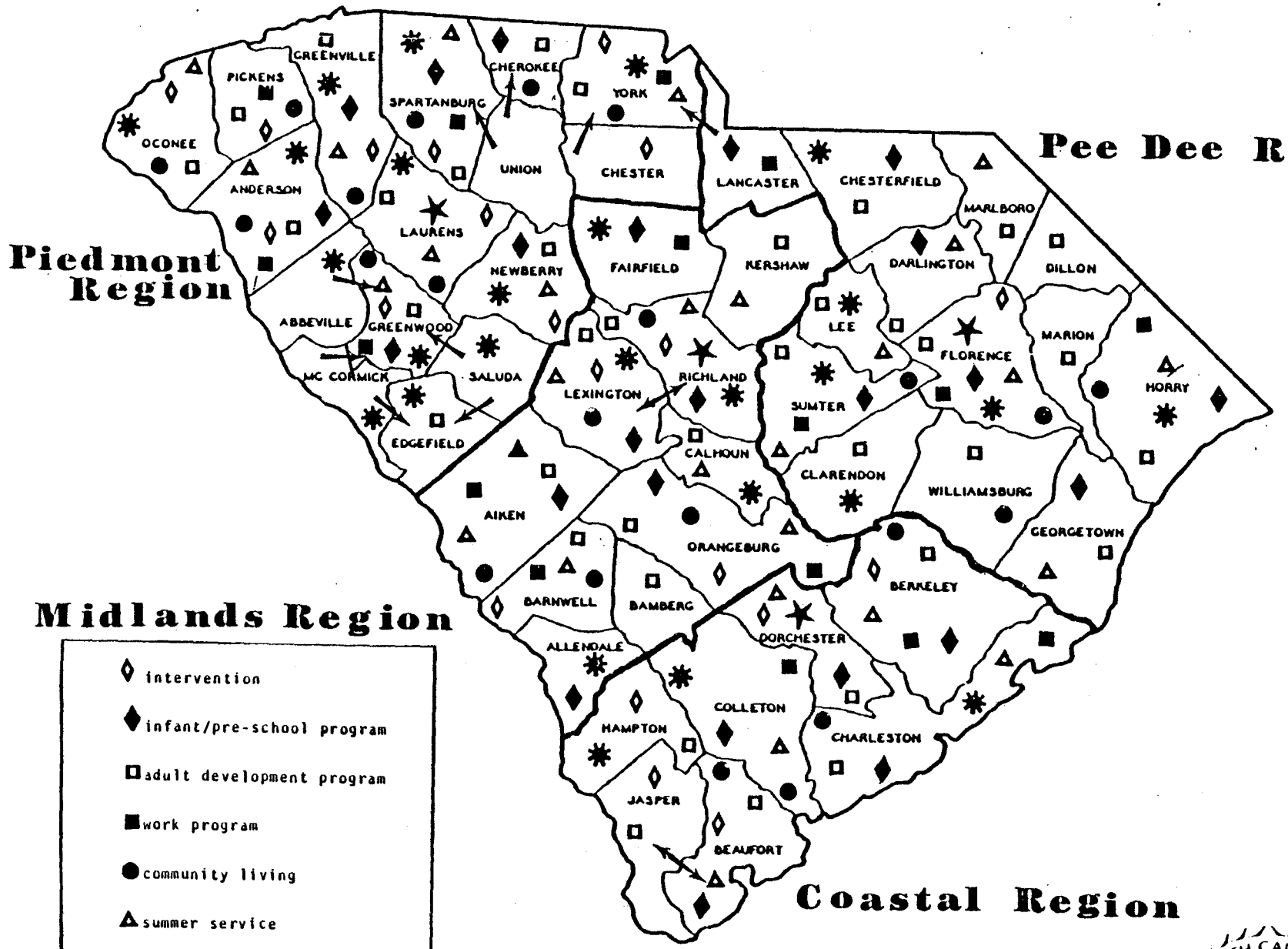

Pee Dee Region
Piedmont Region
Midlands Region
Coastal Region
GREENVILLE
PICKENS
SPARTANBURG
CHEROKEE
YORK
OCONEE
ANDERSON
UNION
CHESTER
LANCASTER
CHESTERFIELD
MARLBORO
LAURENS
NEWBERRY
FAIRFIELD
KERSHAW
DARLINGTON
DILLON
ABBEVILLE
GREENWOOD
LEE
MARION
FLORENCE
MC CORMICK
SALUDA
RICHLAND
LEXINGTON
SUMTER
HORRY
EDGEFIELD
CALHOUN
CLARENDON
WILLIAMSBURG
AIKEN
ORANGEBURG
GEORGETOWN
BERKELEY
BARNWELL
BAMBERG
DORCHESTER
ALLENDALE
COLLETON
HAMPTON
CHARLESTON
JASPER
BEAUFORT
intervention
infant/pre-school program
adult development program
work program
community living
summer service
county MR board
regional center
satellite center
Revised as of 7-31-84
SOUTH CAROLINA
DEPARTMENT OF MENTAL RETARDATION

FIGURE 1

TABLE 3

DEPARTMENT OF MENTAL RETARDATION

SOURCE OF REVENUES AND EXPENDITURES

FY 79-80 THROUGH FY 83-84

Revenue Source	FY 79-80	FY 80-81	FY 81-82	FY 82-83	FY 83-84
Balance from Prior Year	$ 392,946	$ 253,693	$ 779,402	-	-
Regular Appropriations	41,680,628	46,736,287	46,851,456	$49,980,508	$53,517,872
Supplemental Appropriations	253,693	-	-	-	460,000
Transfers between Agencies	-	-	-	-	(24,405)
Lapsed	(231,474)	(106,396)	(7,740)	(42,843)	(965,993)
Carried Forward	(253,693)	(779,402)	-	-	(460,000)
Total General Fund Appro.	$41,842,100	$46,104,182	$47,623,118	$49,937,665	$52,527,474
Total Federal Funds	$ 4,617,365	$ 3,863,613	$ 2,606,212	$ 2,805,738	$ 2,391,189
Other Funds Non-Medicaid	797,856	533,140	1,341,696	575,865	586,652
Other Funds Medicaid	23,055,053	26,824,923	30,446,852	31,955,374	34,811,313
Total Other Funds	$23,852,909	$27,358,063	$31,788,548	$32,363,648	$35,797,965
TOTAL Funds	$70,312,374	$77,325,858	$82,017,878	$85,107,051	$90,716,628
Expenditures by Function					
Administration					
Personal Service	$ 2,508,157	$ 2,694,027	$ 2,819,972	$ 2,946,903	$3,242,399
Other Operating Expenses	524,560	622,660	841,227	944,678	1,019,094
Special Item:					
Voc. Rehab.	164,228	-	-	-	-
Total Case Services/					
Pub. Asst. Payments	-	176,375	258	125,996	45,537
Total Administration	$ 3,196,945	$ 3,493,062	$ 3,661,457	$ 4,017,577	$4,307,030
Services Support					
Personal Service	$ 7,359,666	$ 8,117,025	$ 8,855,541	$ 9,325,205	$9,775,748
Other Operating Expenses	7,079,306	7,654,090	8,377,906	8,523,795	8,304,121
Debt Service	-	-	-	198,283	-
Total Case Services/					
Pub. Asst. Payments	-	1,310	-	-	-
Total Services Support	$14,438,972	$15,772,425	$17,233,447	$18,047,283	$18,079,869
Developmental					
Personal Services	$ 7,226,683	$ 7,566,933	$ 7,492,778	$ 7,206,428	$ 6,979,516
Other Operating Expenses	381,106	378,095	431,092	384,685	378,953
Total Case Services/					
Pub. Asst. Payments	-	2,609	1,416	2,104	2,350
Total Development	$ 7,607,789	$ 7,947,637	$ 7,925,286	$ 7,593,217	$ 7,360,819
Health					
Personal Service	$ 4,903,208	$ 5,385,995	$ 6,786,908	$ 6,739,775	$ 6,859,239
Other Operating Expenses	1,173,709	1,359,231	1,316,467	1,238,906	1,742,845
Total Case Services/					
Pub. Asst. Payments	102,823	50,942	34,719	135,719	163,146
Total Health	$ 6,179,740	$ 6,796,168	$ 8,138,094	$ 8,114,400	$ 8,765,230
Community					
Personal Service	$ 2,667,790	$ 3,029,775	$ 2,951,663	$ 3,151,704	$ 3,301,504
Other Operating Expenses	6,808,785	7,793,587	8,172,461	10,064,759	13,094,644
Total Case Services/					
Pub. Asst. Payments	-	1,786	5,984	867	4,066
Total Community	$ 9,476,575	$10,825,148	$11,130,108	$13,217,330	$16,480,214
Residential					
Personal Service	$20,361,457	$22,647,762	$22,733,489	$22,361,729	$23,199,677
Other Operating Expenses	1,171,404	1,137,503	1,502,998	1,440,269	1,654,381
Total Case Services/					
Pub. Asst. Payments	-	214	17,275	30,146	14,412
Total Residential	$21,532,861	$23,785,479	$24,253,762	$23,832,144	$24,868,470
Prevention & Research					
Personal Service	$ 40,730	$ 52,863	$ 54,973	$ 41,706	$ 58,384
Other Operating Expenses	215,160	217,652	232,979	257,729	266,210
Total Prevention & Research	$ 255,890	$ 270,515	$ 287,952	$ 299,435	$ 324,594
Employee Benefits	$ 7,623,602	$ 8,435,424	$ 9,387,772	$ 9,935,665	$10,530,402
TOTAL Expenditures	$70,312,374	$77,325,858	$82,017,878	$85,107,051	$90,716,628
TOTAL Personnel	4,781	4,954	4,737	4,348.51	4,446.51

Source: South Carolina Budget Document

CHAPTER II

CLIENT SERVICES

Developmental Programs

South Carolina Department of Mental Retardation (DMR) clients are being served in programs which may not be appropriate to their needs. The Audit Council conducted a random sample of residential habilitation plans restricted to educational, residential (living unit) and vocational objectives. The following problems were found: program plans are revised by individuals rather than the prescribed interdisciplinary team; and clients are allowed to continue objectives as stated in habilitation plans without amendments, when no progress is shown in attaining these objectives. These problems are discussed below.

Changes to Habilitation Plans

Habilitation plans have been revised by a single staff person rather than by the entire interdisciplinary team. This could undermine the establishment of a unified, integrated individual treatment plan. The Audit Council reviewed changes to residential habilitation plans for both children and adults from the four regions and found no record of a team meeting held in 64% of the reviewed cases at one region and up to 100% of the cases at others.

DMR uses an interdisciplinary team approach to identify a client's developmental needs. Teams may be composed of a

Qualified Mental Retardation Professional (QMRP), persons from health, developmental, or residential programs, parents, the client when appropriate, and other special services personnel. The QMRP serves as the interdisciplinary team chairperson and unit director for DMR residential facilities.

Problems involving changes in habilitation plans are the result of varying, and in some cases, unwritten policies among the State's four regional centers. Coastal, Midlands and Piedmont Regions require a meeting of all or part of the interdisciplinary team when proposing "major program changes." Pee Dee authorizes the QMRP to determine if a team meeting is necessary. However, no region has established a definition of "a major change."

Thirty-four Code of Federal Regulations 300.343 (Public Law 94-142 "The Education of All Handicapped Children Act") requires each public agency to be:

> ...responsible for initiating and conducting meetings for the purpose of developing, reviewing and revising a handicapped child's individualized education program. [Emphasis Added]

An interpretive comment of this section states that a change in a short-term instructional objective constitutes a revision in the program plan and, therefore, cannot be accomplished without initiating an interdisciplinary team meeting.

The interdisciplinary team approach allows professional and other personnel to work as a team. Each member brings

personal skills, training and experience to the process which helps to ensure the establishment of a unified, integrated individual treatment plan. Since all DMR habilitation plans are developed through an interdisciplinary process, regardless of whether a client is school-aged, policies for revision should apply to all clients.

A policy permitting one interdisciplinary team member to change a program plan may not be in the client's best interest. The person initiating the change may lack sufficient knowledge of the program area. Additionally, since a specific program or plan is an integrated attempt to meet a client's needs, a change in one objective may affect the client's overall plan.

Client Progress

The Department's habilitation or program plans are not reviewed in a timely manner for clients who show a lack of progress. This allows clients to remain in an inappropriate program. The Audit Council found that objectives were continued after the client made no progress for three or more consecutive months in 0% cases reviewed at one region and up to 55% of the cases at others.

The Department uses the Developmental Service Model to treat the mentally retarded. The basic philosophy of this approach is to develop the potential of each client to the highest degree possible rather than to simply maintain the

individual's current level. Consistent with this model, DMR Regulation 88-580(d) of the South Carolina Code of Laws requires that a program plan be maintained for all residential clients. Developed by the interdisciplinary team, the plan outlines what the client should achieve and specific descriptions of the client's daily training program.

No central, uniform policy exists addressing procedures for clients who do not show progress on objectives. Additionally, DHEC has noted problems in its review of patient care plans. DHEC reviews the adequacy of services for all DMR Medicaid clients annually. In 1984, 11% of the patient plans had problems with the lack of monthly review and/or notes on progress. Failure to keep track of individual client progress on goals and objectives hinders appropriate programming.

Public Law 94-142 requires the State "to ensure that a free appropriate education is available to all handicapped children... [Emphasis Added]" Additionally, 42 Code of Federal Regulations 456.610(f1) states an Intermediate Care Facility for the Mentally Retarded (ICF/MR) should determine adequacy of rehabilitative services as evidenced by a planned program of activities to prevent regression. Also, 456.610 (h) states adequacy is based on a client's continual need for placement in a facility or an appropriate plan to transfer the recipient to an alternate method of care.

Further, §44-21-20 of the South Carolina Code requires the State:

> ...to develop, provide, coordinate and improve services for mentally retarded persons to the end that they will be afforded the opportunity to develop their respective mental, physical and social capacities to the fullest extent and to live as normal, useful and productive lives as possible.

Three or more months without progress was used by the Audit Council as an indication that reevaluation of the appropriateness of goals and objectives was needed since two of the four centers use this criteria. Midlands Region Administrative Directive 01-103(VIA3) states: "In cases where three consecutive months of 'no progress' have been noted, the Unit Director/QMRP will contact the discipline involved to review the objectives." In addition, Pee Dee Regional Administrative Directive 03-03 provides that the interdisciplinary team convene special meetings to review lack of progress. According to DMR staff, these two centers adopted a three-month review cycle upon an oral recommendation given by a state-authorized survey team. The other DMR centers (Coastal and Whitten) have no specific time periods to review the program for evidence of a client's lack of progress.

A policy to review the program plan after no progress is necessary to ensure that the client's needs are being addressed. A client permitted to continue an objective with no progress for months without review may not be receiving appropriate programming and may even be showing regression.

Such a program may not allow an individual to reach his optimal level of achievement. Additionally, there is a question of whether agency resources are being used in the most effective manner. Personnel and equipment should be used in the most efficient and effective manner to advance the DMR client. Changes are needed to ensure that the basic philosophy of the Developmental Service Model is followed.

DMR has proposed a shift from a programmatic to a client-centered focus. The implementation of the proposed client-centered system could offer more adequate monitoring to assure quality service delivery in a timely manner.

RECOMMENDATIONS

DMR SHOULD ESTABLISH UNIFORM POLICIES AND PROCEDURES REGARDING REVISION OF CLIENT HABILITATION PLANS. POLICIES SHOULD PROVIDE FOR, AT A MINIMUM, A MEETING OF THE QMRP AND TEAM MEMBERS REPRESENTING THE APPROPRIATE AREA(S), AND SHOULD ENSURE COMPLIANCE WITH PUBLIC LAW 94-142.

DMR SHOULD ESTABLISH A UNIFORM, DEPARTMENT-WIDE POLICY TO REVIEW HABILITATION PLANS WHEN A CLIENT IS NOT MAKING PROGRESS AND, ACCORDINGLY,

REQUIRE REVISION OF THE PLAN TO MORE CLOSELY MEET THE CLIENT'S NEEDS.

Least Restrictive Environment

Handicapped children residing at the four regional centers of the South Carolina Department of Mental Retardation (DMR) may not be receiving education in the least restrictive environment as required by Public Law 94-142. In 1984, there were nine clients from the four regional centers enrolled in public schools. However, according to DMR officials, 57 (9%) of the remaining 646 children residing at DMR regional institutions could attend public school but are not.

One reason cited for this situation is a 1978 Attorney General's opinion which places the educational responsibility for children residing at DMR regional institutions with DMR. Citing the opinion as evidence, at least one local school district has stated that it is not required to serve these children and has refused to do so.

Another contributing factor is the cost associated with educating these children. Under the Education Finance Act local school districts pay approximately 30% of the cost of educating a child. The Audit Council estimates that if all 57 children were to attend public schools, it would add a minimum of $39,000 to the statewide local effort.

Both federal and State law are clear in their intent that handicapped children be educated in the least

restrictive environment. Public Law 94-142 requires the State to establish:

> ...procedures to assure that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily... [Emphasis Added]

Additionally, an interpretive comment on the federal regulations implementing Public Law 94-142 states:

> Regardless of other reasons for institutional placement, no child in an institution who is capable of education in a regular school setting may be denied access to an education in that setting. [Emphasis Added]

Further, §59-33-80 of the South Carolina Code of Laws states:

> The General Assembly declares that the public policy of this state is to provide, when feasible, the resources...necessary to enable the handicapped person to receive an education within the context of his home and community.

Also, §44-21-130 of DMR's enabling legislation states:

> Placement of a mentally retarded person in a facility of the Department shall not preclude his attendance in community based public school classes when the individual qualifies for such classes and when such classes are available.

In 1984, the Babcock Corporation which operates several facilities for the mentally retarded, brought a suit against Richland School District One (and later the State Department of Education) when the District refused to serve four school-aged children living at a Babcock facility. The local school district cited in its arguments §59-63-30 which states that a child's parent or legal guardian must be a legal resident of the district in which the child attends school. However, §59-33-60 states:

> District and State education agencies are required to cooperate with other agencies...both public and private, interested in working toward the education, training and alleviation of the handicaps of handicapped children... [Emphasis Added]

Babcock cited among its arguments Public Law 94-142 which requires that all handicapped children residing in the district be provided a free appropriate public education.

The issue of who should pay the local share of the educational costs for children in group homes has been examined previously. In 1982, the State Department of Education proposed legislation that would make the placing agency or the agency with legal jurisdiction over the child responsible for any educational costs above one pupil's portion of money generated under the Education Finance Act and any federal funds. The bill was defeated.

The Department of Youth Services (DYS), however, has received an appropriation since 1982 to assist local school districts with the excess educational costs of children

placed in their district by DYS. For FY 82-83 and FY 83-84, only $14,772 (21%) of the $70,000 appropriated was disbursed to local school districts.

A federal official has stated that other states handle the question of who should pay the local share in one of two ways. Either the district where the child's parents reside sends money to the district where the child goes to school, or the district where the child resides pays the costs.

Denying a child placement in the most adequate and least restrictive environment is a violation of Section 504 of the Rehabilitation Act. In addition, funds provided to South Carolina under Public Law 94-142 could be lost.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION, THE LOCAL SCHOOL DISTRICTS AND THE STATE DEPARTMENT OF EDUCATION SHOULD DEVELOP AN AGREEMENT TO ALLOW CHILDREN IN DMR REGIONAL INSTITUTIONS TO ATTEND PUBLIC SCHOOL IN COMPLIANCE WITH THE LEAST RESTRICTIVE ENVIRONMENT REQUIREMENT OF PUBLIC LAW 94-142.

THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING LEGISLATION TO CLEARLY DEFINE WHICH ENTITY SHOULD PAY THE LOCAL SHARE OF THE EDUCATIONAL COSTS FOR CHILDREN

ATTENDING SCHOOL OUTSIDE THE DISTRICT WHERE THEIR PARENTS RESIDE.

Special Education Teachers' Salaries

Thirty-eight (76%) of the 50 South Carolina Department of Mental Retardation's (DMR) special education teachers are earning an average salary 10.2% below the annualized minimum salary for South Carolina public school teachers.

Because DMR special education teachers are classified state employees, the starting salary for FY 84-85 is $17,308 for 12 months regardless of education level or experience; however, a public school teacher's salary is based on education level and years of experience. The State public school salary schedule for FY 84-85 sets a minimum salary of $17,528 for a public school teacher with a Bachelor's degree and no experience to $35,494 for a teacher with a Ph.D. and 17 years of experience, annualized to a 12-month school year. Additionally, in FY 83-84, 69 (75%) of the 92 school districts increased this minimum by supplementing the State salary by from .1% to 12%.

Other State agencies do not pay their teachers under the State classification system. The FY 84-85 Appropriations Act specifically exempts teachers employed by the Department of Youth Services (DYS), the South Carolina Department of Corrections (SCDC), and the School for the Deaf and Blind (SDB) from the classification system for State employees. All three agencies use salary schedules

that are modified versions of the public school schedule varying salary by education and experience. At DYS the salary range is set from $17,834 to $35,495; at SCDC the range is from $17,834 to $36,113 for a 12-month school year. At SDB teachers are paid for nine months and the salary range is from $15,516 to $31,420. Teachers are then paid a set daily rate of from $50 to $75 for any days over the 190 teaching days.

The Legislature's intention for all State agency teachers to be compensated with salaries appropriate to those of public school teachers is reflected in the FY 84-85 Appropriations Act which provides:

> Each State agency shall receive such funds as are required to adjust the pay of all certified instructional personnel to the appropriate salary provided by the salary schedules of the surrounding school districts utilized for the 1984-85 school year and subsequent years.

Salary limits imposed by classification of special education teachers at DMR have resulted in teachers with less education and experience. There are fewer (12% versus 40%) special education teachers at DMR with Master's degrees or better than in the public school system statewide. Those with Master's degrees or better at DMR have an average 6.7 years less experience than those in the public school system.

In addition, the classification system has resulted in less pay for those with higher qualifications. For example, in one case a special education teacher at DMR with a

Bachelor's degree and a grade D certificate (lowest) has a higher salary than a teacher with a Master's degree and a grade A certificate (highest).

A DMR special education teacher with a Bachelor's degree and no experience who started when the classification system was instituted in 1979 would be making approximately $18,965 for FY 84-85. A public school teacher who started at the same time would be making an annualized salary of approximately $19,843. However, if during that five-year period both had received their Master's degree, DMR's teacher's salary would be the same, and the public school teacher's salary would be $22,699. Thus, after five years a public school teacher could be making approximately $878 to $3,734 more than a DMR special education teacher.

Both of these factors may have contributed to the 27% turnover DMR experienced from January 1982 to June 1984. From school year 81-82 to school year 82-83, the public school system experienced only a 9.5% turnover for all teachers. Information is not available regarding the turnover rate for the different types of teachers.

Prior to October 1979, DMR teachers were unclassified and were paid based on degree and experience. Reasons cited for changing to classification include the merit and longevity increases offered by classification, the leave benefits, the 12-month school year, and existing inconsistencies in salary among the different regions. Longevity increases are granted for individuals who have

been at the maximum pay level for their grade over the past two previous years. These amount to 5% every two years for eight years. Of the 50 teachers currently employed at DMR only one has received a longevity pay increase. Teachers at DYS, SCDC, and SDB earn annual and sick leave benefits just as those at DMR and as other State employees.

The Audit Council estimates that it would cost a minimum of $76,000 to bring the teaching positions at DMR to the annualized minimum for public school teachers. One possible source for the funds would be the transfer of funds from six vacant teaching positions already funded at DMR. For FY 84-85, DMR has 72 special education teacher positions and 646 students. Elimination of the six vacant positions would allow DMR to adjust the salaries of the remaining special education teachers to public school levels and still meet the ratio of one teacher for every ten children desired by DMR staff. Additionally, DMR's five-year plan calls for expansion of the program for placement of school-aged children in community residences. Thus the number of special education teachers needed to meet the ratio should decline.

RECOMMENDATION

DMR SPECIAL EDUCATION TEACHING POSITIONS SHOULD BE UNCLASSIFIED AND TEACHERS SHOULD BE PAID USING A SALARY SCHEDULE

SIMILAR TO THE STATEWIDE MINIMUM PUBLIC SCHOOL SALARY SCHEDULE.

Alternative Residential Care Programs for Children

The Department of Mental Retardation (DMR) has not provided adequate alternative residential care programs for mentally retarded children; it has kept a number of clients for whom community placement is more appropriate in the most restrictive environment. The Department has had approximately 416 children, 17 years of age or younger, in institutional care. The length of their institutional placement ranged from several months to 17 years. In November 1983, DMR referred over 60 children, who in its judgement did not require institutional care and could live in a family environment, to the Department of Social Services (DSS).

Currently, the Department's alternative residential care programs for children are limited to two eight-bed community residences in one region and foster homes in another region. These are licensed by DSS for clients in the custody of DSS. These programs presently serve 33 clients under 18 years of age. DMR phased out its department-wide foster care program (Home Care) in 1981.

The Department of Mental Retardation has not taken adequate initiatives in developing a continuum of alternative care programs for mentally retarded children.

The Department also has not ensured that adequate programs are available to all children who need them in each region.

Section 44-21-140 of the South Carolina Code of Laws requires the Department to refer persons appropriate for foster care to DSS for placement. DSS is required to attempt to place those persons referred by DMR. Although DMR had made no official referrals prior to November 1983, the Department had attempted to develop a placement agreement with DSS beginning in 1980. According to Department officials, a lack of cooperation between the two agencies inhibited the process. However, this problem has been resolved to some extent with a recent agreement with DSS regarding licensure of DMR's proposed Community Training Home Program.

DMR is charged with developing more normalized, less restrictive alternatives to institutional care. Section 44-21-810 states:

> ...that the public policy of this State is to provide, when feasible, the resources, assistance, coordination and support to permit mentally retarded persons to remain in their natural homes or if this is not possible or desirable, to live in a community setting having characteristics as near to normal for their age as their particular capacities will permit.

Section 44-21-20 states:

> Where residential placement becomes necessary, it should be recognized that many mentally retarded persons can and should be returned to their homes and communities after appropriate periods of special treatment and training.

The establishment and operation of a continuum of community and residential programs has been authorized by the Commission on Mental Retardation in its Policy Number 23 dated August 9, 1979. This policy further states:

> ...the full range of Departmental programs and services be available to all Departmental clients, as individually determined to be most appropriate and least restrictive.

The lack of the alternative care programs in DMR's regions has several effects. First, some mentally retarded children, who in the judgement of the Department, are appropriate for less restrictive settings, are now placed in a more restrictive setting. The two programs that DMR does offer are very limited and are not operated in all of the regions. Thus, the opportunities for placement in appropriate less restrictive settings are available to some Departmental clients and not to others. The Department's present foster care program is further restricted by limiting participation in the program to DMR clients in the custody of DSS.

Alternatives to institutional care can be more economical. Some studies have shown that care in alternate living arrangements tend to be less expensive or at least no more expensive than institutional care. One of the more inexpensive, least restrictive and more normalized arrangements, is family care. An Audit Council survey of southeastern states, shown on Table 4, supports this fact.

TABLE 4

AVERAGE ANNUAL COST OF CARE BY TYPE OF PLACEMENT

States	Cost Per Client		
	Institutional	Group Home	Foster Care[1]
Southeastern States	$30,000 - $40,000	$10,000 - $18,500	$5,000 - $12,000
South Carolina	$22,400	$17,000 - $21,400	$5,360[2]

[1]Foster Care figures do not include medical costs covered by Medicaid.
[2]Cost includes board payment and training supplements.

Source: South Carolina Department of Mental Retardation
Southeastern States (Alabama, Florida, Kentucky, North Carolina, Tennessee and Virginia)

In early 1984, DSS and DMR developed a pilot adoption program. Under this program, DSS will attempt to place five Departmental clients in adoptive homes.

DMR also began developing standards in late 1983, for one-bed to three-bed training homes to serve children and adults. It is estimated that, currently, 310 retarded persons need a community training home. Department officials expect the first of these homes to be opened in early 1985. In addition, one of the four regions has proposed the development of two six-bed community residences for children. The first home is expected to be opened in early 1985.

RECOMMENDATION

A PRIMARY GOAL OF THE DEPARTMENT SHOULD BE TO PROVIDE SERVICES AND ASSISTANCE SO MENTALLY RETARDED CHILDREN CAN BE RETURNED TO, OR REMAIN IN, THEIR NATURAL HOMES. WHEN THIS IS NOT FEASIBLE, THE

DEPARTMENT SHOULD ENSURE THAT AN APPROPRIATE CONTINUUM OF LIVING ARRANGEMENTS FOR CHILDREN ARE AVAILABLE, STATEWIDE, TO ALLOW PLACEMENT IN THE LEAST RESTRICTIVE SETTING.

Client Protection

The Audit Council examined the Department's methods for investigating and reporting client abuse. Samples of alleged abuse cases were drawn at each of the four regional centers. Although the Audit Council found no major problems with the system as it presently exists, the investigation revealed problems which increase the potential for a breakdown in the reporting system and thus the protection of clients. These are discussed below.

Implementation of Abuse Policies

Disposition of alleged abuse cases varies from region to region. The Audit Council's review of alleged abuse cases and their investigations revealed questionable determinations in 10 (11%) of the cases sampled.

In at least three instances employees were suspended from duty, rather than terminated, for "negligence" or "negligence in performance of duties." In one case employees who were aware that a client was "eating soil out of the toilet" took no follow-up action to clean the client's teeth or mouth. In another case, two employees who

were originally terminated for abuse by neglect, for not bathing or changing a client, were reinstated upon appeal to the regional superintendent. It was determined by the superintendent that abuse was not substantiated and the two employees were reinstated but suspended for three days for negligence. [Emphasis Added] In the third instance, although abuse could not be substantiated in the case of an LPN accused of giving clients their morning and afternoon medications at the same time, the employee was suspended for three days for negligence. [Emphasis Added]

Other examples include a case where "abuse was not intended" because the employee did not view a client's cleaning out a toilet with his hands as dehumanizing or degrading for the severely retarded client. Instead, a written warning for "use of poor judgement" was issued. In another case, an MRS admitted to having threatened a client with a cane to calm him down, but also stated that he had no intention of hurting the client. This was not found to be substantiated abuse but rather "use of poor judgement and overreaction" for which the employee received a two-day suspension.

Another problem with implementing Department policy which could result in a detrimental situation to clients is illustrated by the case where an assistant administrator issued written reprimands to employees for reporting abuse out of the "chain-of-command." These reprimands were subsequently removed from the personnel files; however, no

action was taken against the administrator who issued them. Review of the files indicates that this administrator has been counselled on other occasions concerning the need to adhere to and comply with abuse reporting.

In some cases, the regions are not following Departmental policies and definitions regarding abuse. DMR clearly defines neglect as:

> The absence of apparent and necessary action to insure safety and well-being of a client.

Neglect is included in the definition of abuse in §II.B of Administrative Directive 81-06. In addition, whether there was intent to abuse is irrelevant based on this directive which also states:

> An action...is deemed intentional when prohibited by law or Departmental directives or when such action is manifested in inhumane, degrading or unconscionable acts or conduct.

Thus, the act of allowing a client to clean a toilet in the manner described and the admission of the mental retardation specialist that he did threaten a client with a cane appear to fall under the categories of emotional abuse and threatened abuse, respectively. Both of these are defined by DMR as abuse and are punishable by termination.

Another cause for questionable determinations in abuse cases is ambiguity in both Departmental and regional policies. DMR Administrative Directive 83-09 defines critical incidents as:

> ...events involving Departmental clients, employees, or property which

> have harmful or otherwise special effects.

Examples include, among other things, "maltreatment of individuals" and "other situations judged by the Superintendent to be unusually significant or of high public interest." There are no definitions provided for such terms as "unusually significant," or "high public interest."

In addition, there are no guidelines provided to distinguish maltreatment of an individual from abuse or neglect and, in fact, in one regional policy listing examples of critical incidents, maltreatment is listed as:

> Maltreatment (abuse) of individuals. [Emphasis Added]

As noted in the minutes from an Employee Advisory Council meeting from that region:

> Critical incidents may or may not differ from abuse. Judgement is required.

In another region, the official charged with making final decisions in cases stated that the distinction between maltreatment and abuse and/or neglect depends upon criteria such as the severity of harm to the client and the severity of the actual neglect. Action taken against an employee may also depend on where that employee functions in the progressive disciplinary policy.

Definitions of abuse, neglect, and other incidents relating to client protection should specifically delineate proscribed acts, allowing little regional interpretation.

Ambiguity can result in subjective and inconsistent decisions being made at all levels in the abuse reporting

system. This undermines confidence that reporting potentially abusive incidents will result in an equitable disposition of the case. In addition, confusion as to what employees must or should report can result. Inconsistency within the system lessens protection for both clients and employees and could potentially increase liability for the Department.

Conduct of Investigations

The Audit Council sampled abuse cases at each of the four regional centers and found evidence of conflicts in the appointment of investigators for alleged or suspected abuse cases.

At Whitten Center four (15%) of 27 investigator appointments since 1982 presented conflict of interest problems. In one instance an investigation of alleged abuse within the residential program was conducted by the Residential Program Administrator. The abuse, originally substantiated, was overturned because, among other reasons, the investigator could not be considered neutral.

The other three cases were investigated by the wife of the Assistant Superintendent to whom all alleged abuse cases are reported. Although none of the cases appeared to contain improprieties, and this investigator was appointed from outside the program area where the alleged abuse occurred, the potential for or appearance of conflict exists.

At Pee Dee Center the Audit Council found that in four (25%) instances of alleged abuse since 1982 cases were being investigated by individuals appointed from within the same program area. A review of data entered on the alleged abuse log also revealed seven other cases where the investigator appeared to have a connection with the program area under investigation and, therefore, presented a conflict of interest problem.

The review of cases sampled at Coastal Center revealed one similar conflict in the appointment of investigators. The sample reviewed at Midlands also revealed only one instance of potential conflict. In this case an Assistant Superintendent was appointed to investigate an alleged abuse which involved the Center's other Assistant Superintendent.

Regions where the appointment of investigators has resulted in a conflict have not followed Departmental policies. An addendum to Administrative Directive 81-06 states:

> ...The investigation of alleged client abuse must be conducted by an employee outside the program area where the abuse allegedly occurred. The abuse investigation should not be tainted by any possible conflict of interest due to the investigator's connection with the program area under investigation. [Emphasis Added]

Although at least two of the examples noted technically do not violate this directive in that the investigators were appointed from outside the program area, even the appearance of a conflict should be avoided.

Conflicts may directly affect the validity of an investigation and may thus hamper the types of sanctions imposed. They may also undermine confidence in the objectivity of the system resulting in a decrease in the Department's ability to effectively monitor and control abuse and thereby protect its clients.

Timeliness of Investigations

The Audit Council's review of alleged abuse cases indicates that formal investigations of these cases at Whitten Center are not begun in a timely manner.

From the sample of cases drawn, the Audit Council determined that at Whitten an average of six days lapsed between the time an alleged abuse occurred and the time that a trained investigator was appointed to conduct a formal investigation. At Coastal Center the average time was two days and at Midlands and Pee Dee Centers one day.

One reason noted for the delay is the lengthy preliminary investigation and review process. This includes initial gathering of data, reporting to and review by the program administrator before a determination is made as to the need for further investigation. In addition, there are no departmental or State requirements concerning the immediacy with which investigations should begin.

According to a 1984 study, funded by the United States Department of Health and Human Services, investigations of

reported acts of abuse and neglect should begin within 24 hours of the receipt of the report.

Failure to begin investigations in a timely manner has several effects. Statements from individuals involved might tend to become more unreliable as time passes. Clients could have a difficult time retaining facts, and where given more time employees might have discussed incidents among themselves. In addition, other evidence such as marks or bruises to the body could fade or disappear over time making it more difficult to ascribe a particular injury to a particular time and/or place. As a result, documentation becomes more unreliable. In turn, the actions which can be taken in the cases of suspected abuse are hampered and the protection offered clients is decreased.

Conclusion

Although no widespread problem of unreported abuse or administrative mishandling of alleged abuse cases was uncovered, the problems noted above can have a major impact on client health and safety. The potential for breakdowns in the system is increased when the agency which is responsible for providing, supervising and regulating care and services to the client is also the agency primarily responsible for investigating abuse and neglect occurring in the delivery of such care and services. Although DMR does forward records of abuse investigations to the State Ombudsman's Office, there is a need for establishing a

mechanism which would automatically trigger initial investigations by an outside, independent agency. This would more adequately ensure the protection of clients entrusted to the Department.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION CENTRAL OFFICE SHOULD SET ALL POLICY CONCERNING CLIENT PROTECTION FOR THE REGIONS. SUCH POLICY SHOULD PROVIDE THE REGIONAL STAFF CLEAR DEFINITIONS OF ABUSE AND NEGLECT.

THE CENTRAL OFFICE SHOULD MONITOR MORE CLOSELY THE IMPLEMENTATION OF POLICIES TO ENSURE CONSISTENCY IN THE DISPOSITION OF ABUSE CASES.

REGIONAL ADMINISTRATORS SHOULD MORE CLOSELY MONITOR APPOINTMENT OF INVESTIGATORS IN ORDER TO ENSURE EQUITABLE DISPOSITION OF ABUSE INVESTIGATIONS AND TO AVOID CONFLICTS OF INTEREST.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD REQUIRE THAT FORMAL

INVESTIGATIONS OF ALLEGED ABUSE BEGIN WITHIN 24 HOURS OF THE INITIAL REPORT.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD COORDINATE WITH THE STATE OMBUDSMAN'S OFFICE TO CONSIDER IMPLEMENTING AN INDEPENDENT AGENCY INVESTIGATIVE SYSTEM FOR ALL ALLEGED ABUSE REPORTS.

Referral to DSS and FCRB

The Department of Mental Retardation (DMR) did not properly review for placement, cases it referred to the Department of Social Services (DSS) for adoptive or foster home placement, and to the Foster Care Review Board (FCRB) for review and alternative placement recommendations. This resulted in inclusion of inappropriate cases and unnecessary time spent in the referral process.

Foster care review boards review periodically cases of children who have resided in private or public foster care (foster family, institutional, or group home care) for more than six months to assess efforts and make recommendations regarding acquiring a permanent home for these children. DSS provides protective, placement and other human services.

Twenty-three percent (20) of the 87 cases referred to the FCRB in November 1983 (see p. 27), were dropped because they were found to be inappropriate for home placement due

to the level of care required. Sixty-one of these 87 cases were also referred to DSS. Cases dropped involved clients who did not meet selection criteria because they required skilled care nursing, or had behavioral problems or special needs making placement in a family unit undesirable.

The regions have not followed the specified referral criteria jointly developed by FCRB and DMR, which state that referrals should include clients who do not require institutional level of care and could live in a family unit. Other criteria state that clients should be those who are 17 years of age or younger and are visited infrequently or not at all by their parents.

Eleven cases were dropped by foster care review boards. One region dropped three of the cases it referred. In addition, interdisciplinary teams assessments done at one region after the referral of 26 clients to FCRB and 17 of the same clients to DSS, resulted in six cases being dropped. Cases dropped by this region alone amounted to 30% of the cases dropped.

According to officials at each of the regions, individual social workers were asked to review their caseloads to determine which children met the criteria rather than using the interdisciplinary team approach already in place for determining client placement. These teams are interdisciplinary and able to provide a broader and more comprehensive assessment of the clients. Teams include social workers, mental retardation specialists,

representatives from the medical discipline and other staff services.

Inadequate staff review of clients referred for placement services has several effects. First, children who are inappropriate for such placement have been referred, while others who are appropriate may have been excluded. In the interest of providing the highest quality of treatment and care for clients and making the most efficient use of State resources, only appropriate cases should be referred for placement services. The selection of cases for referral by the interdisciplinary team approach should reduce the number of inappropriate cases and thereby expenditures on the part of both the referring agency and the service provider. Additionally, a more timely resolution of proper placement may be achieved for the client.

Recommendations for alternate care should be made by the interdisciplinary habilitation or program teams who are responsible for a client's total plan for daily living. According to 42 Code of Federal Regulations 442.422 relating to the standards for Intermediate Care Facilities for the Mentally Retarded (ICF/MR), the teams should review at least annually the client's progress and recommend alternatives for continuing care with suggestions for meeting objectives. Addendum staffings may be held during the interim. Staff at each of the regional centers told the Audit Council that this is their placement policy. When followed, this

procedure allows for a more comprehensive assessment of clients' needs and appropriate programming.

RECOMMENDATION

THE DEPARTMENT SHOULD ADHERE TO STANDARDS FOR INSTITUTIONS FOR THE MENTALLY RETARDED WHICH REQUIRE THAT INTERDISCIPLINARY TEAMS ASSESS THE NEED FOR CONTINUING INSTITUTIONAL CARE AND CONSIDERATION OF ALTERNATE CARE ARRANGEMENTS.

Regional Staff Training Programs

The Department of Mental Retardation (DMR) has not provided adequate direction and coordination of staff training at the regions. This has resulted in problems which could affect client care. The following is a discussion of four problems found with regional staff training programs.

First, regional staff training requirements are not standard for any phase of the program: orientation, direct care staff inservice or on-the-job training (OJT). While the subject content covered in these training programs is similar, there are significant variances in the length and intensity of training in the individual subject areas. The regions' orientation for new employees varies in length from four to seven days; inservice which direct care workers

receive ranges in length from one to five days; and the length of OJT programs varies from zero to three days.

Additionally, specific courses vary. For example, training in the management of client behavior varies from four to fourteen hours, and courses in cardio-pulmonary resuscitation (CPR)and defensive driving are optional at one center. Also, training for supervisory personnel is not required at one center, while others have individual requirements that differ. No center requires alternate direct care supervisors (MRS IIIs) to have training in supervision.

The second problem is that methods of evaluating trainees differ among the four regions. The evaluation of trainees on subjects other than standardized courses, i.e., first aid, CPR, and defensive driving, are not uniform. The subjects tested and the depth of the tests vary, and there are limited checks on performance. There are no competency or performance evaluations in most of the OJT programs even though the Department's policy does specify emphasis shall be given to monthly supervisory OJT reports during the six-month probationary period.

Third, the Department has no preservice training requirements. New employees, particularly direct care workers, are allowed to begin work in their assigned units without training or orientation. Some 168 Mental Retardation Specialists, hired between January 1, 1982 and May 1, 1984, at one of the centers were allowed to begin

work without any training. Some worked as long as three months prior to receiving training. However, this center implemented a one-day preservice training program in November 1984.

The final problem is that the Department has no staff training standards for community programs, and there are no regional training requirements for these programs. An exception is that new employees of DMR operated community programs participate in the regional centers' orientation and direct care staff inservice. Only one region has an orientation and inservice training program designed for community programs. However, some regions do provide an orientation for staff and operators of newly established facilities. This training is conducted by a center staff trainer who functions primarily as a trainer for community programs staff. The other regions provide training at the provider's request, or at the recommendation of the region's Community Programs Division staff.

DMR has limited and non-specific policies regarding staff development, leaving the regions responsible for their own staff development and training programs; however, meetings between persons holding similar positions at each region were not required by the central office. The Department has only recently designated a staff member to coordinate and direct training, in an attempt to ensure that program quality is maintained and desired results are achieved. Variations in the content, emphasis and length of

basic training provided employees may influence the general quality and adequacy of staff training.

Because direct care workers play an important role in the development and care of the individual client, the extent and quality of the training provided them has a significant impact on the well-being of the Department's clients. These factors also affect the liability and level of risk inherent in providing such care.

Standardized minimum requirements could be developed for the general orientation and in-service training for direct care workers within the Department. Requirements could be specified in departmental policies and directives. New employees, particularly direct care workers, generally have little background or knowledge in the care, treatment and training of mentally retarded persons. The Department employs over 1,800 mental retardation specialists to work with over 2,700 clients. Approximately 79% of the MRS I's, II's and III's have a high school education or less. These employees are responsible for providing care, supervision and training to clients on a 24-hour basis and have the greatest amount of individual contact with clients of any direct service group. According to the Position Questionnaire for an entry-level direct care position, 60% to 75% of this employee's time is spent with the client.

Further, employees should be evaluated to determine the level of their knowledge and skill competency, and to determine the effectiveness of the training provided them.

Employees who do not demonstrate the minimum competencies should not work in the client care areas.

Also, supervisory training should be provided to supervisors and alternate supervisors. According to 42 Code of Federal Regulations 442.432, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must have a staff training program that includes supervisory and management training for all employees in, or candidates for, supervisory positions.

A survey of seven southeastern states showed more than half of these states have minimum training requirements which consist of either core curricula or core topics. The remainder indicated they intend to develop minimum standard curricula or improve present training curricula. More than 80% of the states surveyed indicated they have central training officers and conduct meetings between persons holding similar positions at different centers on a quarterly basis at a minimum.

Mississippi recently upgraded its entire direct care program. The State now requires the completion of a 360-hour direct care preservice training program. This is offered through the State's junior college system and funded through the Job Training Partnership Act. As an alternative, direct care employees may complete a staff training program offered at the institutions which will involve an intensive, supervised OJT program when fully implemented. Approximately one-third to one-half of the

college program is supervised practicums. Employees hired prior to the implementation of the new training program will be required to demonstrate competencies based on the new training standards, or they will be transferred to another area.

RECOMMENDATIONS

THE DEPARTMENT SHOULD ESTABLISH A CENTRAL TRAINING AND EDUCATION LIAISON TO COORDINATE AND FURTHER DEVELOP ITS STAFF TRAINING AND DEVELOPMENT PROGRAM.

DMR SHOULD DEVELOP, IN CONJUNCTION WITH THE REGIONAL STAFF DEVELOPMENT OFFICERS, PRESERVICE AND INSERVICE STAFF TRAINING CORE CURRICULA SPECIFYING MINIMUM COURSES, COURSE OBJECTIVES, LENGTHS, AND EVALUATION INSTRUMENTS FOR COMMUNITY AND INSTITUTIONAL STAFF AT ALL REGIONS. PARTICULAR ATTENTION SHOULD BE GIVEN TO PRESERVICE AND INSERVICE TRAINING FOR DIRECT CARE STAFF. PROVISIONS SHOULD BE MADE TO UPDATE THESE CURRICULA ON A CONTINUING BASIS.

DMR SHOULD ESTABLISH TRAINING STANDARDS FOR ITS COMMUNITY PROGRAMS AND DESIGNATE A STAFF TRAINER FOR COMMUNITY PROGRAMS.

THE DEPARTMENT SHOULD REQUIRE STAFF DEVELOPMENT MEETINGS BE HELD ON A REGULAR BASIS BETWEEN PERSONS HOLDING SIMILAR POSITIONS AT DIFFERENT REGIONS.

CHAPTER III

FINANCE AND ADMINISTRATION

Reimbursement for Educational Costs

The Department of Mental Retardation is continuing to claim educational costs presently under review by the federal government. An audit was performed by the Federal Health and Human Services Department (HHS) of claims made by DMR as allowed by their contract with the State Health and Human Services Finance Commission (HHSFC). This report, released in December 1984, questions almost $7.2 million in educational and related services costs claimed under Title XIX of the Social Security Act Medical Assistance Program (Medicaid).

The State Auditor's Office and a HHSFC official have stated DMR should continue to claim these costs to avoid undermining the State's position. DMR will be able to participate in an appeal process at the federal level to eliminate all or a portion of the questioned costs. If the Department is dissatisfied with the results of the appeal process court action may be taken.

HHS maintains DMR is in violation of 42 Code of Federal Regulations 441.13(b) which states, in part:

> Payments to institutions for the mentally retarded...may not include reimbursement for vocational training and educational activities. [Emphasis Added]

DMR has stated the disallowance of educational costs under the Medicaid program is a recent nationwide trend. Additionally, according to DMR and HHSFC, the federal government has failed to clearly define education and to differentiate between educational and habilitative services. DMR argues the services provided by the Department should be considered habilitative rather than educational. Therefore, DMR feels that Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are responsible for providing these services based on 42 Code of Federal Regulations 442.463(a) which states:

> The ICF/MR must provide training and habilitation services to all residents, regardless of age, degree of retardation, or accompanying disabilities or handicaps. [Emphasis Added]

However, Decision No. 367 and No. 438 of the HHS Departmental Grant Appeals Board upheld disallowances for educational services in Oklahoma and educational and vocational training in Massachusetts in 1982 and 1983, respectively.

A conclusion that can be drawn based on the Massachusetts case is that the State will most likely have to reimburse the federal government $3 million claimed in educational services provided to school-aged clients. The State plans to appeal this amount and any additional liability.

The effect of DMR's continuing to claim the questionable costs is that additional liability may be

incurred by the State for FY 83-84 and FY 84-85. DMR has stated that beginning in FY 85-86 the educational costs will no longer be claimed under Medicaid. Additionally, the Department has requested $3.1 million to cover possible disallowances of educational costs for school-aged clients which might be incurred from FY 83-84 through FY 84-85. In effect, the Department has opted to obligate State dollars to cover additional disallowed costs which may be incurred by continuing to claim these costs.

However, if the Department were allowed to use client fees as operating revenue (see p. 87), obligation of State funds may be reduced. The Federal Health Care Financing Administration stated March 19, 1985 that current regulations regarding the treatment of clients' income (see p. 53) reflect Congressional intent to have a client with income defray the cost of his/her institutional care to the extent possible. As of April 1985, the Department's surplus debt service account contained $3.9 million which could cover the estimated potential loss of federal funds for educational services, estimated to be $1.6 million for FY 84-85.

RECOMMENDATION

IF THE STATE IS FOUND LIABLE FOR REIMBURSEMENT OF DISALLOWED EDUCATIONAL COSTS, THE GENERAL ASSEMBLY SHOULD CONSIDER ALLOWING SURPLUS DEBT SERVICE

(CLIENT FEES) TO BE USED AS REVENUE TO COVER EXPENSES.

Management of Client Funds

The Audit Council in its review noted problems with the management of client funds. This has resulted in a loss of revenues to South Carolina, as well as subjective and questionable charges to clients' personal accounts.

Federal regulations require that Medicaid clients receive a personal needs allowance of at least $25 per month from recurring income such as Social Security benefits. South Carolina, in its State Plan approved for implementing federal regulations, restricts the allowance to a $25 minimum for personal needs. The balance of the recurring income is deposited with the State Treasurer.

DMR has chosen through its Administrative Directive 82-02 to allow a client to retain 25% or $25, whichever is greater, of any recurring income. This practice is in conflict with the State Plan noted above, and has, by allowing clients to keep more than $25 per month for personal needs, led to the following two problems:
(1) client care and maintenance costs the State more; and
(2) client accounts grow large and threaten Medicaid eligibility, leading to subjective and questionable charges to clients' personal accounts.

Care and Maintenance Charges

DMR has not complied with the State Plan under Title XIX of the Social Security Act Medical Assistance Program (Medicaid) regarding clients' use of recurring monthly income. The Audit Council reviewed cases for FY 83-84 at each of the four regions and found that DMR's policy of allowing clients to retain 25% of their recurring income has resulted in a loss of approximately 12% to the State ($248,000) of client support for care and maintenance services.

The Procurement Audit and Certification Section of the South Carolina Division of General Services noted in its May 1983 report of DMR that there is no provision in either federal or State law that allows DMR an expenditure in excess of $25 per month on behalf of the client for personal needs.

Also, an official of the Federal Health Care Financing Administration has stated, the $25 monthly allowance for personal needs is reasonable, with any exceptions to be documented by the clients' program teams. The Controller of the North Carolina Department of Mental Retardation also told the Audit Council that only under "extraordinary" circumstances is the $25 monthly allowance exceeded in that state.

The $248,000 amount represents an annual amount that the State could save, if the clients retained the amount established by the State Plan and contributed the balance

toward care and maintenance expenses. DMR has proposed a change in its Administrative Directive 82-02 which would allow a client to keep $25 of his Social Security or other earned income. This proposal is under review by the State Health and Human Services Finance Commission.

Charges to Clients' Personal Accounts

The Department of Mental Retardation has used two methods to reduce client accounts which are nearing the maximum amount for retaining Medicaid eligibility. First, DMR has been inconsistent and judgemental in the application of additional care and maintenance charges to clients' accounts. Second, DMR has also followed a practice of using large and questionable purchases to "spend-down" clients' accounts.

Because DMR allows clients to retain 25% of their recurring monthly income, clients' personal accounts can accumulate significant balances which threaten Medicaid eligibility. Medicaid eligibility is denied when clients have income/resources greater than $1,500. In these cases, DMR has inconsistently and subjectively charged additional care and maintenance as one way to maintain Medicaid eligibility.

When such charges are made, DMR's Administrative Directive 82-02 does not provide the specific guidelines needed to ensure uniformity and consistency. Internal Audit Report No. 83-10 stated each center has a different method

for the charging of additional care and maintenance if a client's account reaches $1,200. The regions rarely charge additional maintenance and, when charged, it is deducted from the next month's Medicaid reimbursement claim. A 1983 internal audit investigation of Midlands Center was conducted based upon a parent's inquiry into the reasons for numerous charges against her son's account. It was ascertained the account had been inappropriately charged care and maintenance charges of $830.65. Subsequently, DMR reimbursed the account for this amount.

As a second method of keeping clients' accounts within the Medicaid eligible limitation, DMR has used periodic "spend-down" or purchases to control balances. Client purchases accounted for over $1.4 million at the four regions for FY 83-84. This figure does not include care and maintenance or other expenditures and transfers, and accounts for approximately 35% of total expenditures from client accounts.

Following are examples of questionable purchases to clients' personal accounts noted by the Audit Council in a test of unusual items at Whitten Center. These purchases occurred from FY 79-80 through FY 83-84.

1. A skilled nursing facility at Whitten Center purchased eight color televisions from a local department store with $300 from each of eight residents' personal accounts.

2. One client had two disco parties costing $1,500 and $650.

3. Golf carts were purchased with client funds, even after an Attorney General's Opinion prohibited the carts from the streets and sidewalks of the campus.

4. One female client collected a $400 air hockey game, a $1,659 pinball machine, and over $1,300 in furniture.

5. Numerous purchases of color televisions and stereos, chairs and other furnishings were made.

6. Furniture totaling $10,700 was bought from one company and charged against 16 clients' accounts.

7. Off-campus dinners and birthday parties for entire units, including staff, were financed by individuals.

Included in the voucher package for the first purchase noted here was a memo from the Assistant Superintendent to the Administrator of Residential Programs. It stated:

> We have been bombarded with large purchases for clients. This apparently is an effort to draw down their funds so that they can be eligible for Medicaid or to spend their funds prior to the State assessing them monies for care and maintenance. The judgement being used in much of this has been very poor. An example is $1,800 which one client spent for patio furniture...It is very likely that Social Security will be displeased with that purchase. Another example is the eight color televisions purchased... which will not be used for at least another year...

DMR's financial report for admissions requires parents, guardians, or legal representatives to agree that if Medicaid eligibility is denied due to income/resources greater than $1,500, the Department may bill the client's personal account for services until Medicaid eligibility is reestablished. However, DMR's Administrative Directive 82-02, as previously noted, is in contrast to this statement and instructs:

> To prevent disruption in Medicaid eligibility, clients will be allowed to accumulate no more than $1,200 in their combined accounts. This amount or less will be controlled by adjustment of the amount of personal funds allowed monthly, or if necessary, by periodic spenddown. [Emphasis Added]

The effect of questionable purchases with clients' personal funds in the past has been abuse of the Department's responsibility. As a guardian of clients' personal funds, the DMR centers are expected to properly coordinate clients' needs along with management of their funds.

Purchases from clients' personal funds are justified whenever there is a basic personal or habilitative need. The burden of proof in these cases is on the clients' program teams. However, DMR must respond to benefactors such as the Social Security Administration in justifying client purchases with their funds.

A review of FY 83-84 purchases at two regions revealed that one region continues to allow large purchases. Large purchases of televisions, clothing, toys and games are still being made when accounts near the $1,200 - $1,300 amount. One client, with a $1,566 balance, was given a $600 "buying spree" in July 1984. The other regions showed practically no large or unusual purchases.

A proposed amendment to Administrative Directive 82-02, previously noted, continues to call for control of the balance by monthly adjustment of the amount of personal

needs allowance as a first priority and charges for additional care and maintenance as a second. For those clients with $1,600 or more resources, the full cost of service will be assessed until eligibility is reestablished. Additionally, the Department feels that the implementation of Administrative Directive 85-01 will prohibit the purchase of items for common areas, such as furniture, out of client personal funds.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD ADHERE TO THE STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM REGARDING CLIENTS' PERSONAL NEEDS ALLOWANCES. IF A CLIENT IS DENIED MEDICAID ELIGIBILITY DUE TO INCOME/RESOURCES, DMR SHOULD CHARGE THE CLIENT'S PERSONAL FUNDS FOR THE COST OF SERVICES UNTIL ELIGIBILITY IS REESTABLISHED.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD PROVIDE STRICT OVERSIGHT OF REGIONAL ACCOUNTS RECEIVABLE PRACTICES TO ENSURE EQUITABLE AND CONSISTENT CHARGING OF CARE AND MAINTENANCE FEES

AND PROPER MONITORING OF PURCHASES FROM PERSONAL ACCOUNTS.

Third Party Debt Collection

DMR is not receiving revenue to which it is entitled for care and maintenance. Some parents and guardians have failed to remit to the Department portions of the client's recurring income (Social Security) for services, when the parent or guardian is the third party recipient of the checks.

An official of the Department has stated that DMR is stymied in its enforcement powers and needs a stronger law in order to collect the full amount due. Additionally, a January 1984 internal audit report on DMR's accounts receivable system stated:

> Our audit of the departmental...system as well as our review of the prior audit conducted by the State Auditors revealed that the overall system does not provide for adequate internal controls.

After detailing nine areas of concern, including third party debt collection, the report states that problems stem from reliance on an antiquated system, incomplete written procedures and a lack of clear policies. Finally, the State Auditor has stated both in 1978 and 1982 audits of the Department that internal control over care and maintenance charges and receipts is extremely limited. Revisions to the system, expected by July 1981, have not yet been made.

An official of DMR stated the Department would like to establish a landmark case wherein other cases might be pursued for collection. However, §44-21-260 of the South Carolina Code of Laws appears to give DMR broad powers regarding debt collection. It states: "...the Department may utilize all legal procedures to collect lawful claims."

In June 1984, DMR wrote off $132,000 in uncollectible bad debts arising from pre-1980 parent charges and charges for respite care. If a more viable enforcement system had been established, these amounts may have been collected.

As a result of the findings by the DMR internal auditor, the Department is in the process of revising its policy on fees for services provided, and has added personnel who will implement and administer a new automated accounts receivable system.

RECOMMENDATION

DMR SHOULD ATTEMPT COLLECTION OF LAWFUL THIRD PARTY DEBT USING NECESSARY LEGAL PROCEDURES. IF NECESSARY, THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING THE SOUTH CAROLINA CODE OF LAWS TO PROVIDE THE DEPARTMENT OF MENTAL RETARDATION WITH MORE ENFORCEMENT POWER TO COLLECT FUNDS DUE.

Transfer of Client Funds

Client personal funds are not forwarded as required when clients are transferred to another region or discharged from the State's care. The Audit Council sampled personal fund accounts for 403 clients from all regions who were transferred or discharged. The review showed that during FY 82-83 and FY 83-84, where a determination was possible, $88,901 of client funds were not transferred within the required five days. This accounted for non-compliance in almost 90% of the cases sampled.

The regional centers do not keep the client personal fund accounts in a manner which allows for prompt closing of accounts. Practice at the regions has been to close accounts in 30 days. However, even this practice is not always followed.

Forty-two Code of Federal Regulations 442.406 requires an Intermediate Care Facility for the Mentally Retarded (ICF/MR) to return to the transferred or discharged client, all or any part of his/her funds held in the facility. The Regulations further stipulate any funds held outside of the facility must be returned to the client within five (5) business days. In addition, the Department of Mental Retardation's Administrative Directive 81-04 states:

> Upon transfer or discharge of a resident, the Department will return all funds to the resident, parent/guardian or other responsible party within 5 business days.

The regions have not complied with the Federal Regulations or the Administrative Directive.

The Department serves as the custodian of the client personal funds entrusted to it. Improper management of client funds results in less accountability and increases the potential for abuse of these funds. For example, the Audit Council found that in one region client accounts had been closed without properly accounting for all outstanding debts. DMR should monitor the regions for compliance with Federal Regulations and the Department's Administrative Directive concerning the transfer of client funds.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD COMPLY WITH 42 CODE OF FEDERAL REGULATIONS 442.406 AND WITH THE DEPARTMENT'S ADMINISTRATIVE DIRECTIVE 81-04 TO ENSURE A CLIENT'S PERSONAL FUNDS ARE TRANSFERRED AS STIPULATED.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD DEVELOP AN ACCOUNTING SYSTEM THAT WOULD ENSURE ACCURATE AND TIMELY CLOSING OF CLIENT PERSONAL ACCOUNTS.

Medicaid Cost Settlements

The Department of Mental Retardation (DMR) has received large Medicaid cost settlements for prior year expenditures for services provided at Intermediate Care Facilities for the Mentally Retarded (ICF/MR) under Title XIX of the Social Security Act Medical Assistance Program (Medicaid). For the past three years, FY 81-82 through FY 83-84, the settlements amount to almost $6.4 million. This results in the use of an average of 2.1 million State dollars a year until the cost settlement is received.

The cost settlements are higher than necessary because the reimbursement rate is based on outdated costs. DMR is thus reimbursed at a rate which has been lower than actual costs incurred during the year in question. This is due, in part, to an 18-month lag created by the method used to determine the per diem rate. DMR contracts with an independent CPA firm to prepare the cost reports based on the prior year expenditures. Currently, these reports are used by the State Health and Human Services Finance Commission (HHSFC) and, prior to its creation, the Department of Social Services, to set the new per diem rate for Medicaid reimbursement and to determine any cost settlement due to DMR for services provided during the prior year. Therefore, once the actual costs have been determined, DMR receives a cost settlement to cover the difference and repay State dollars spent.

Section 160 of the Appropriations Act for FY 83-84 requires all agencies to return to the General Fund any reimbursements received from federal funds. However, Section 40 of the Appropriations Acts for FY 83-84 and FY 84-85 grants DMR the authority to use the prior year Medicaid cost settlements until July 1, 1985. Therefore, not only are State dollars obligated unnecessarily, they are also in this case exempted from return to the General Fund.

Because the per diem rate is too low to properly reflect current costs of operating an ICF/MR, State funds are obligated for operations until the cost settlement is received. In this way, costs due must be absorbed by the Department's operating budget.

It is crucial for DMR to more closely align the reimbursement rate to actual costs of operating the ICF/MR's. In March, DMR and HHSFC implemented an inflation factor of 5.1% to more accurately reflect the reimbursement rate. This factor will be applied retroactively to January 1985 to reduce the need for a larger than necessary cost settlement.

An alternative solution would be for DMR to develop the capability to produce the cost reports in-house, permitting interim reports. Currently, the Department of Mental Health produces Medicaid cost reports in-house on a personal computer. DMR is the only State agency contracting with an independent CPA firm for the reports, a practice considered preferrable by the HHSFC. Development of cost reports

in-house to be audited by an outside entity would not change the CPA responsibility for the verification of the allowable Medicaid costs annually. In-house development of interim reports would allow DMR to gain control over Medicaid reimbursements. Additionally, DMR would be able to periodically compare the actual operating costs to the per diem rate of reimbursement, permitting an "as needed" adjustment of the per diem rate. This would provide a more accurate reflection of actual costs in a more timely manner thus avoiding the obligation of an unnecessary amount of State funds until federal reimbursement is made.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD DEVELOP THE CAPACITY TO PRODUCE IN-HOUSE MEDICAID COST REPORTS TO BE AUDITED BY A CPA FIRM TO ENSURE VALIDITY.

THESE COST REPORTS SHOULD BE USED PERIODICALLY TO MAKE ANY NEEDED ADJUSTMENT OF THE PER DIEM RATE TO MORE ACCURATELY REFLECT ACTUAL COSTS.

Pharmacy Operations

There is a lack of accountability at one of the Department of Mental Retardation's pharmacies, and problems with uniformity among the three centers operating in-house pharmacies. The Audit Council, assisted by the Narcotics and Drug Control Section of the Department of Health and Environmental Control (DHEC), reviewed the management of controlled substances at Whitten, Coastal and Midlands Centers. Pee Dee Center was not included since it operates on a contractual basis with a local retail drugstore rather than operating an in-house pharmacy. From this examination, the following problems were found.

Regional Accountability

The Audit Council and DHEC attempted to perform an accountability audit at Coastal Center in May 1984. DHEC officials concluded:

> ...Coastal Center... does not have an accurate and readily retrievable system for accountability purposes and an accurate audit of controlled substances is not possible at this time. [Emphasis Added]

Additionally, the Audit Council and DHEC noted overstocked and crowded conditions within the pharmacy, threats to security, and a large supply of out-of-date drugs in both the workstations and a supply room. The Audit Council also noted a destruction of ten injections of morphine in June 1980 not witnessed by a representative of DHEC, as required.

The review examined controlled drugs, which have a high potential for abuse and habit-formation. Also, the record keeping for non-controlled drugs was reviewed, although no accountability testing was performed on them. The centers' 1983 biennial physical counts of controlled substances, required by federal and State law, were used as the beginning balance. From this point, the progression of these balances was documented by adding in receipts from suppliers, deleting any destructions and dispensed dosages and arriving at a closing balance. Any differences between this closing balance and what the Audit Council and DHEC physically counted on a certain date were noted as audit exceptions. Coastal Center had an overall error rate of 24%, compared to Whitten's 1% and Midlands' 1.4%. See Table 5 for examples of some audit exceptions at the three DMR pharmacies.

TABLE 5

EXCERPT OF AUDIT EXCEPTIONS AT DMR PHARMACIES

	Whitten	Midlands	Coastal
Ritalin, 10 mg tabs	+11	-0-	+281
Chloral Hydrate 500 mg caps	(not counted)	-17	+2,501
Darvocet N-100 tabs	0	-20	+189
Phenobarbital 30 mg tabs	-49	+284	-1,006
Valium 5 mg tabs	-69	-261	+13,344

In a report to the Audit Council in June 1984, DHEC described the following problems in Coastal's operations:

(1) Coastal's 1983 biennial (end of April) count of controlled substances was improperly performed by its pharmacists and was unreliable as to completeness.

(2) The Coastal Center does not have a satisfactory system of keeping and retrieving records of receipt of controlled substances. According to DHEC:

> ...all (pharmacy) registrants must maintain accurate and readily retrievable records of receipt of controlled substances.

Except for some narcotic substances, there were no perpetual records of controlled or non-controlled drugs at Coastal.

(3) The Coastal Center does not accurately account for or secure returns of take-home medications. The Audit Council observed over 90 partially-filled vials of controlled and non-controlled drugs on countertops in the pharmacy. Also, the center has not accurately credited the client's original prescription for amounts returned, nor has it adjusted subsequent prescriptions for left-overs. DHEC has raised the issue of possible unknown contamination or adulteration of returned drugs occurring during home visits; thus, drugs returned should be destroyed rather than redispensed.

(4) DHEC labeled the dispensing record-keeping system "poorly administered," "fragmented," and "unsatisfactory." Index cards are the primary dispensing record. The Audit Council and DHEC estimated the card supply for the one year

under examination at 40,000 cards. Duplication of index cards was found for the same pills dispensed more than once. Also, the card's quantity information was not reliable to determine any unused drugs.

(5) DHEC and the Audit Council observed Valium and other drugs within reach of a hallway dispensing window. Although the window's metal curtain is closed when no one is in the pharmacy, the pharmacists working at their workstations cannot adequately monitor the window.

Another security and accountability problem was noted in the delivery of controlled substances to the Coastal Center. All drugs are delivered to the Center's general warehouse, where the drugs are checked in and later sent to the pharmacy. DHEC noted it would be more appropriate to have controlled drugs delivered directly to the pharmacy. Also, because of inadequate handling of purchase order records, the pharmacist cannot tell if orders have arrived. Further, the original requisitions are not checked against invoices from the drug companies.

Based on the Audit Council's and DHEC's observations of the lack of perpetual records of inventory levels, the large quantities on hand, and the poor housekeeping of the pharmacy, the pharmacist cannot adequately monitor purchase needs. Thus, the potential exists for the State to be purchasing drugs which have not been requisitioned or which have been requisitioned improperly. Also, unnecessary emergency purchases from local wholesale or retail vendors

could result in higher prices paid outside the systemwide drug bid.

Coastal Center's problems have been caused by poor management within the pharmacy itself and at the regional level, as well as a lack of oversight by the DMR Central Office. Although the Audit Council found no evidence of intent, malicious or otherwise, to divert controlled substances, the system in place does not provide accountability for the drugs handled.

After reviewing all three regions with in-house pharmacies, the Audit Council and DHEC noted Whitten's pharmacy operations to be superior to the other regions'. The only problem noted at Whitten was failure to include all drug locations on their 1983 biennial inventory. Midlands also has an accountable system, although dispensing records for controlled drugs are not kept "readily retrievable," as required by DHEC. Both Whitten and Midlands maintain perpetual inventory records on their controlled drugs.

The lack of accountability in Coastal's system for dispensing controlled and non-controlled substances could allow diversions to go undetected. Also, depending on the client's functional level, it would be difficult to document that a client was actually administered his medication. Client health and safety is thus endangered. In addition, unnecessary purchases of supplies result in misuse of State and federal (Medicaid) funds.

Regional Uniformity

The Audit Council found a lack of uniformity in other areas among the three regions operating in-house pharmacies. These include workload and inventory stock levels.

As shown in Table 6, Whitten's four pharmacists have a heavier workload than the other centers, yet it operates the most accountable system in the State. Whitten dispenses drugs on a 28-day basis, whereas Coastal dispenses on a 7-day and Midlands a 2-day basis. According to DHEC, dispensing a 7-day supply is preferred and would avoid having too many drugs in the cottages at one time.

TABLE 6

WORKLOAD ANALYSIS FOR FY 83-84

UNIT DOSAGES DISPENSED PER MONTH PER PHARMACIST

Center	Per Month Unit Dosages	Pharmacists	Pharmacy Technicians
Whitten	46,750	4	2
Coastal	33,333	2	1
Midlands	25,040	4	2

Whitten dispenses out of bulk bottles, while the other two pharmacies dispense unit dosage packages. Athough the merits of unit dose include ease of handling and less likelihood of misadministration of medications because of individually marked packages, unit dose packaging is more expensive than bulk.

Factors such as the composition of functional levels at each region and the degree of clinical pharmacology administered could account for some of these workload differences. Also, the physical facilities and work environments are varied among the regions. However, the workload analysis raises questions concerning efficiency in operation.

A Central Office physical inventory of all pharmaceutical supplies taken June 30, 1984, after the Audit Council and DHEC examinations, confirmed that there is no causal relationship between inventory and client number. Coastal's pharmacy has a much higher level of inventory, even though it is smaller than Midlands'.

The DMR Internal Auditor's report on the June 30, 1984 inventory showed the following balances:

Midlands	$40,047
Coastal	72,836
Whitten	85,674

As was found at Coastal, large quantities on hand lead to inventory becoming out-of-date. The Narcotics and Drug Control Section of DHEC noted a 45-day supply on hand to be adequate for pharmacies such as DMR's. Also, the pharmacies run the risk of staff doctors no longer prescribing the same drugs over an extended period of time, perhaps due to the availabilty of new drugs. Although the DMR pharmacies operate from a formulary and order according to an annual

systemwide drug bid, old supplies may accumulate and go unused.

Conclusion

More conformity and communication among the regional pharmacies would ensure a more equitable level of service to the Department's clients. An anticipated computer software system for the pharmacies will aid accountability and record keeping, but the basic problems at Coastal must be corrected before a new approach is undertaken. There is also a need for more regional and Central Office oversight of pharmacy operations.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD ENSURE, WITH ADVICE AND ASSISTANCE FROM THE NARCOTIC AND DRUG CONTROL SECTION OF DHEC, THAT A SYSTEM OF ACCOUNTABILITY IS ESTABLISHED AT THE COASTAL CENTER PHARMACY SUCH AS IS IN PLACE AT WHITTEN CENTER.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD REQUEST THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL'S NARCOTIC AND DRUG CONTROL SECTION TO PERFORM ACCOUNTABILITY AUDITS OF THE DMR

PHARMACIES AT LEAST EVERY TWO YEARS. THESE AUDITS SHOULD FOLLOW THE ODD-YEAR FEDERALLY REQUIRED COUNTS OF CONTROLLED SUBSTANCES.

THE DMR CENTERS SHOULD KEEP PERPETUAL RECORDS OF BOTH CONTROLLED AND NON-CONTROLLED SUBSTANCES. THE INTERNAL AUDITORS SHOULD MONITOR NON-CONTROLLED DRUGS WITH HIGH DOLLAR VALUES AND THOSE LIKELY TO BE ABUSED.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD ENSURE UNIFORMITY AMONG ITS THREE REGIONAL PHARMACIES, IN ORDER TO PROVIDE EQUITABLE CLIENT SERVICES.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD ENSURE ITS PHARMACIES: KEEP EMERGENCY PURCHASES TO A MINIMUM; RETURN OUT-OF-DATE DRUGS FOR REBATES; INCLUDE ALL DRUG LOCATIONS ON INVENTORIES; MAINTAIN ACCURATE AND READILY RETRIEVABLE DISPENSING RECORDS FOR CONTROLLED SUBSTANCES; DISPENSE DRUG SUPPLIES ON A SEVEN-DAY BASIS; AND COMPUTERIZE PHARMACY RECORDS.

Use of State-Owned Housing

DMR pays partial living costs of some employees. Reduced cost housing is provided certain Department of Mental Retardation employees at Whitten Center. The Department loses over $9,000 per year since the monthly rental charges are not based on fair market value.

The Department owns eight houses which are located on the Whitten Center Campus. The houses are valued at $411,693 (adjusted for location on campus). The average value per house is $51,461. The houses are occupied by physicians and administrators. These residences are maintained only for the benefit of the employees, and are not necessary for the Department's operations of patient care. Presently, none of the other mental retardation centers maintain housing for employees. However, Midlands Center provided housing for its Superintendent until October 1983. The Department no longer leases this residence. The Department also owned several other houses, once used to house employees, which have been converted either to client housing or office use or which have been demolished.

The fair rental values of the eight houses at Whitten Center ranged from $85 to $220 per month, based upon appraisals completed in 1975. The Department adjusted these values in December 1983, based on the increase in the value of the houses since 1975. The adjusted values now range from $100 to $295 per month (see Table 7).

TABLE 7

SUMMARY OF RENTAL VALUES AND RENTAL RATES

FOR STAFF HOUSING AT WHITTEN CENTER

Building Number	Fair Market Rental Value (1975)	Monthly Rental Charge Thru June 1984	Fair Market Rental Value (1983)	Monthly Rental Charge Effective July 1984
3207 (100)	$ 90	$75	$100	$ 50
3208 (101)	130	75	134	75
3206 (102)	85	75	125	50
3204 (103)	220	90	295	100
3205 (104)	155	85	162	75
3201 (105)	140	75	178	75
3203 (107)	200	85	203	100
3202 (108)	200	85	207	100

In January 1984, the Department instituted a new rental policy which required occupants to pay the cost of utilities or a rental charge, whichever is greater. The actual rental charges, which have remained the same since 1974 in spite of the DMR adjustment study, vary from $75 to $90 a month. These charges remain lower than the fair market rate established in 1975. Prior to February, the occupants paid only the rental charge, but did not pay for services (electricity, natural gas, sewer and water). Structural and yard maintenance on these houses is also done by the Department at no charge to the occupants.

In June 1984, DMR revised this policy. Departmental policy now requires occupants to pay rent plus the actual usage costs for all utilities. Occupants are now charged for sewer service and are also required to maintain their yards. However, the rental charges are still below market rental value established in 1975.

According to Department officials, free and reduced cost housing has been used to recruit physicians. Administrators also live in these houses and have done so for several years. While DMR has been aware of the market rental values of these houses, it has chosen not to set and charge appropriate rental rates. Further, for a considerable period of time the Department chose not to charge residents for utility and maintenance services, even after this policy was questioned by other Whitten Center employees.

Providing free and reduced cost housing is an additional fringe benefit which is contrary to State law. Section 134 of the FY 83-84 Appropriations Act states:

> The salaries paid to officers and employees of the State, including its several boards, commissions and institutions shall be in full for all services rendered, and no perquisites of offices or of employment shall be allowed in addition thereto, but such perquisites, commodities, services or other benefits shall be charged for at the prevailing local value and without the purpose or effect of increasing compensation of said officer or employee. ...Provided, however, that this shall not apply to the...nurses and attendants at the Department of Mental Retardation...

Further, State and federal tax regulations consider housing not provided at the employer's convenience or as a condition of employment to be compensation and therefore taxable. The taxable value of the compensation is equal to the fair market value of the housing.

Providing free and reduced cost housing as well as other costs of living has several effects. First, the taxpayers are subsidizing the housing costs of certain Department of Mental Retardation employees. In FY 82-83, the State could have collected an additional $6,900 in rent, if rental charges had been based on the 1975 fair market rental values. Between January and June 1984, the Department could have collected approximately $8,100 additional rent had rent been based on the adjusted fair market values prepared by the Department in 1983. The actual rent collected by the Department during this period amounted to less than $350 after subtracting utility costs.

Under the current rental policy DMR will lose over $9,000 per year in rent based on the Department's 1983 adjusted rental values.

Further, unpaid taxes on such compensation represents uncollected tax revenues owed to the State and federal government.

Finally, the Department is treating employees inequitably. Employees not living in the Department's houses are required to pay the full cost of housing they incur. Providing housing benefits to Department of Mental Retardation employees is contrary to the State personnel system which is to ensure equal treatment and benefits for all State employees. Finally, DMR has stated its intention to expand community placement programs. Existing facilities could be used to provide transition for selected clients.

RECOMMENDATION

THE DEPARTMENT SHOULD CONSIDER CONVERTING THE HOUSES TO OTHER NEEDED USES, SUCH AS TRANSITIONAL AND SEMI-INDEPENDENT LIVING UNITS FOR ITS CLIENTS. UNTIL SUCH TIME AS THE CONVERSIONS CAN BE MADE, CHARGES SHOULD BE INCREASED TO REFLECT THE FAIR RENTAL VALUE.

Budget Management

The Department of Mental Retardation (DMR) has had budgetary problems in the past. According to a DMR official, year-end transfers of appropriations between programs occurred in order to pay incurred expenditures.

In August 1982, regions were allowed to adjust their programs' budgets for FY 82-83. This was after the Budget and Control Board had approved that year's budget request in Fall 1981, and the General Assembly had made an appropriation, by program, in Spring 1982.

The FY 82-83 transfers, which were approved by the Budget and Control Board, reallocated $1.3 million in State and other funds away from the Developmental and Residential programs. The net changes of these funds added $897,000 to the Services Support Program, $338,000 to the Health Program, and $64,000 to the Community Program to meet their expenditures. These reallocations are in addition to over

$800,000 transferred among programs for deinstitutionalization and over $2 million in a 4.6% systemwide reduction mandated by the Governor.

This problem exists, in part, due to lump-sum allocations from the General Assembly which allowed more latitude within the agency to meet expenditures. Since July 1, 1983, the Department has reviewed appropriations on a line-item basis.

Further, in the past, lack of regional input into the budget-making process has hindered the communication of regional needs and expenditures. Programmatic budgeting has also contributed, although the Department contends it can ascertain program costs better in this manner.

Additionally, due to poor data processing capabilities in prior years, Central Office monitoring of regional expenditures to budget was a manual, time-consuming task. As recently as Spring 1984, when an anticipated on-line budget system for FY 83-84 was not working, the Central Office handled a lot of the regions' financial activity through the end of the fiscal year.

Finally, DMR does not have an integrated accounting system to include ledger and transaction reports, as well as an encumbrance system as required by generally accepted accounting principles for a governmental entity. An encumbrance system formally encumbers funds for certain expenditures at the point of the purchase order. It

controls anticipated expenditures at year-end and reserves funds for them.

According to the Government Finance Officers Association, a good budget is the following:

(1) A policy document of the entity's operating plan.

(2) An operations guide and framework for making policy decisions.

(3) A financial plan of the sources and uses of funds and resources.

(4) A communications medium for disclosure of the entity's financial, strategic, and operational information.

Inherent in governmental accounting is the adequate management of public funds. Because DMR did not exercise adequate foresight for its programs' needs, particularly in FY 82-83, mid-year and end-of-year budget transfers were required to find funds to pay for expenditures. These transfers continued through FY 83-84. A proviso in the FY 84-85 Appropriations Act requires agencies to budget and allocate funds to provide for operations on a uniform standard of expenditures to avoid a deficit.

In an effort to acquire tighter control over funds in FY 83-84, the Central Office took over regional budget responsibility within program lines. However, in FY 84-85, the on-line budget data system, while limited, is working. The regional staff are maintaining their budgets at the major and minor object code level within programs. All

checks are generated by the Comptroller General's Office, which has controls in place if funds are inadequate in the line-item to pay for the expenditure. The new budget system, along with an anticipated encumbrance system, will enhance accountability and will help avoid unnecessary or unapproved expenditures of State and other funds.

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD STRIVE TO INCORPORATE MORE REGIONAL INPUT INTO ITS BUDGET PROCESS. ADDITIONALLY, DMR SHOULD CLOSELY MONITOR PROGRAM BUDGETS AT BOTH THE CENTRAL OFFICE AND REGIONAL LEVELS.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD IMPLEMENT AN ENCUMBRANCE SYSTEM, IN ORDER TO BRING IT MORE IN LINE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES AND TO PROVIDE MORE ACCOUNTABILITY OVER FUNDS.

Implementation of State Auditor's Recommendations

The Department of Mental Retardation has not implemented, on a timely basis, recommendations from the State Auditor's June 30, 1978 Management Letter. These

recommendations relate to improvements needed for fiscal accountability of the Department. Again on June 30, 1982 as in FY 77-78, the State Auditor disclaimed an opinion on the reliability of DMR's financial statements.

The Audit Council has noted five major areas of the 1978 Management Letter which remained largely unchanged in FY 81-82 according to the State Auditor's Management Letter released in March 1985. Areas in the Department's accounting and control system that need improvement include the following:

(1) General Accounting Records:

Proper recording and documentation of grant monies is needed. The ledger is not integrated with transaction reports.

(2) Care and Maintenance Receivables:

Separation of duties, proper recording, documentation, and reconciliation of receivables, as well as, internal control over additions and deletions of funds from clients' personal accounts is needed.

(3) Purchasing and Supplies:

Separation of accounting control and physical asset custody is needed. Other deficiencies include lack of integration of inventory control and general accounting records, failure to age inventory and maximize use of the computer for usage projection, and lack of control over

miscellaneous inventory. Purchase orders need to be issued before the fact.

(4) Cash Receipts:

Implementation of a statewide data system is needed for proper recording and documentation of the nature and purpose of cash receipts and other revenue.

(5) Canteen Operations:

Proper recording, documentation, and reconciliation of canteen general operating funds and related profits is needed. Fund balances should be expended by the Department.

These issues have remained unresolved due to DMR's placing little emphasis over the last few years on developing policy and correcting deficiencies in its financial system. The slow growth of data processing capabilities at DMR has also hurt their efforts.

The DMR Commission established an Audit Committee of its members and an internal audit department to review and make recommendations for changes. Also, DMR has responded to the State Auditor with time lines for correcting existing deficiencies.

According to the State Auditor's Office, more changes as a result of the June 30, 1978 Management Letter could have been accomplished as of the June 30, 1982 Management Letter. A reasonable period of time for implementation was estimated to be six months to a year.

The Permanent Provisions of the FY 81-82 Appropriations Act provide:

> ...that the State Budget and Control Board shall withhold Funds Appropriated to State Agencies for Failure to Comply with Management Letters Issued by the State Auditor.

Consequently, until corrections are implemented adequately and in a timely manner, DMR risks having funds withheld by the Budget and Control Board from its State appropriations. Failure to implement recommendations contributes to the lack of a sound financial system at DMR and prevents the Department from receiving an unqualified opinion from the State Auditor on its financial statements.

RECOMMENDATION

DMR SHOULD ESTABLISH A POLICY TO ENSURE TIMELY CORRECTIVE ACTION ON AUDIT RECOMMENDATIONS, PLACING RESPONSIBILITY ON KEY MANAGEMENT WITH THE ASSISTANCE OF THE DMR INTERNAL AUDITOR FOR FOLLOW-UP.

Client Fees for Construction

Since 1979, the Department of Mental Retardation has used over $1.5 million of surplus debt service or excess client fees which are more than those needed for the payment of bonded indebtedness, for the construction, purchase and/or renovation of community residences for lease to private providers. This is allowed under §44-21-1080 of the

South Carolina Code of Laws with approval by the Budget and Control Board.

A survey of the southeastern states revealed that South Carolina is the only state that uses excess client fees for the construction of community residences for the mentally retarded. Common practice is to use client fees to cover operating expenses. The four states which have constructed one or more community residences for lease to private providers have primarily relied upon state appropriations. Additionally, two states have used either state bonds or Medicaid funds to supplement the appropriation.

The use of client fees may result in clients who will probably remain in institutions funding the construction of facilities for others. A better use of client fees would be to fund, as much as possible, services which directly benefit the client who pays. Also, if client fees were used to cover operating expenses and private sector construction of community residential facilities were increased (see p. 88), DMR could reduce the amount of State funds appropriated for these costs.

RECOMMENDATION

THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING §44-21-1080 OF THE SOUTH CAROLINA CODE OF LAWS TO PHASE OUT THE USE OF SURPLUS DEBT SERVICE (CLIENT FEES) TO FUND THE CONSTRUCTION OR

PURCHASE AND RENOVATION OF COMMUNITY RESIDENCES FOR LEASE TO PRIVATE VENDORS. CLIENT FEES COULD BE USED AS OPERATING REVENUE TO COVER THE EXPENSES OF SERVICES PROVIDED TO CLIENTS UNDER STATE CARE.

Construction of Community Residences

DMR is obligating State monies for the continued construction of community residential facilities because it has not actively promoted private sector involvement. The Department of Mental Retardation proposes to continue the construction of community residences for lease to private non-profit providers through FY 87-88 and possibly through FY 89-90.

On April 29, 1980, the Budget and Control Board authorized DMR to lease a DMR constructed community residence to a private non-profit provider. At this time, the Commissioner of DMR stated that the lease agreement was a transitional step designed to encourage private non-profit providers to construct and operate community residential facilities.

Currently, DMR leases out 15 community residences which cost over $2.3 million to construct or purchase and renovate. These residences were intended to serve as an initiative for private individuals to enter into the

provision of services, thereby relieving DMR from being the sole provider.

A survey of the southeastern states revealed four other states have constructed one or more community residences for lease to private providers. These states have relied basically upon state appropriations which may have been either supplemented from the local level, state bonds or Medicaid. South Carolina has used mainly surplus client fees (see p. 86).

Michigan does not use state funds for the construction of community residential facilities for the mentally retarded. Instead, construction is done by a private investor who, in turn, leases the facility back to the Michigan Department of Mental Health. The agreement generally stipulates the facility must be leased to Michigan's Department of Mental Health for 20 years. The State of South Carolina is working out, for other agencies, the details for two lease-back agreements in the State. Private investors will purchase these buildings and in turn lease them back to the State. The Department could then contract with private vendors for service.

To date, DMR has provided letters of support to providers seeking Housing and Urban Development grants for the development of community residential facilities. Additionally, one meeting has been held between DMR and private contractors to discuss the possibility of lease-back agreements. This practice coincides with the emphasis on

providing the most normalized and least restrictive living environment.

However, the Department's Five-Year Plan proposes construction of community residences through FY 87-88 at costs of $5.2 million and most likely through FY 89-90 at additional costs of $6.5 million. This results in a higher than necessary State appropriation (see p. 86).

RECOMMENDATIONS

THE DEPARTMENT OF MENTAL RETARDATION SHOULD ACTIVELY WORK TO PROMOTE THE CONSTRUCTION AND OPERATION OF COMMUNITY RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED BY PRIVATE NON-PROFIT INDIVIDUALS.

THE DEPARTMENT OF MENTAL RETARDATION SHOULD CONSIDER IMPLEMENTING A LEASE-BACK AGREEMENT FOR THE CONSTRUCTION OF COMMUNITY RESIDENTIAL FACILITIES BY THE PRIVATE SECTOR.

Commission Membership

There are no mental retardation specialists, physicians, or educators on the Mental Retardation Commission. The Commission consists of seven members with

backgrounds in chemistry, journalism, business and other non-mental retardation and non-medical areas. The recent appointment of one member has added an educator to this body.

Section 44-19-30 of the South Carolina Code of Laws which creates the Commission does not establish any requirements for members with mental retardation, medical or education backgrounds. The law states in part:

> There is hereby created for the Department the South Carolina Mental Retardation Commission, hereinafter referred to as the Commission. The Commission shall consist of seven members, one to be a resident of each Congressional district and one from the State at large to be appointed by the Governor upon the advice and consent of the Senate.

The Commission is established as the governing body of the State Department of Mental Retardation. It has jurisdiction over all public institutions within the State for mentally retarded persons including community service programs.

The Commission is empowered to determine the policy and adopt necessary rules and regulations governing the operation of the Department and the employment of professional staff and personnel. Commission members with a mental retardation, medical or education background can provide valuable input into policies established by the Commission and balance the interests of laymen on the Board. The introduction of new perspectives to meetings or decision making is more likely under these conditions, and the

public's confidence could be better served regarding decisions rendered by the Commission.

RECOMMENDATION

THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING §44-19-30 OF THE SOUTH CAROLINA CODE TO REQUIRE REASONABLE REPRESENTATION FOR MENTAL RETARDATION SPECIALISTS, PHYSICIANS AND EDUCATORS ON THE COMMISSION.

Functioning of County Mental Retardation Boards

Countywide planning, coordination, and review and evaluation of county mental retardation services by the County Mental Retardation (MR) Boards is generally limited.

Section 44-21-840 of the South Carolina Code of Laws provides for mental retardation boards to be the planning, coordinating and service delivery bodies of county mental retardation services funded by DMR. Section 44-21-850 requires DMR to review the service plans, and offer consultation and direction to the boards. The boards are also mandated to review and evaluate mental retardation services; plan, arrange, and implement working agreements with other agencies, and submit service plans. The board may also deliver and contract mental retardation services. In many cases, however, the boards' functions are limited to

operating programs and endorsing funding requests to the Department from private program providers.

The formal reviews and evaluations of non-board operated county services are generally very limited, yet the boards endorse the funding requests of these programs. In counties which do not have MR boards, there is no organized method established to carry out these functions.

This situation exists because DMR has not been successful in encouraging the establishment of boards in all counties. There are 21 counties which do not have such boards; however, 90% of these counties do have provider programs that receive funds from DMR for the delivery of county mental retardation services.

Also, the Department of Mental Retardation has not provided sufficient direction and guidelines to encourage boards to carry out their prescribed functions. The reporting requirements of DMR do not encourage comprehensive assessments. Also, the boards do not use standard evaluation and review methods.

The development and delivery of a comprehensive, integrated county service program as projected in the Department's Five-Year Plan is dependent to a great degree on the efforts of the boards, and thus may be hindered by the present conditions. Furthermore, the services cannot be adequately assessed as required without reasonably comprehensive reviews and evaluations of the entire county mental retardation program.

RECOMMENDATIONS

DMR SHOULD INCREASE ITS EFFORTS TO ENCOURAGE THE ESTABLISHMENT OF COUNTY MENTAL RETARDATION BOARDS IN ALL COUNTIES OF THE STATE THROUGH WORKING WITH COUNTY GOVERNING BODIES AND LOCAL ORGANIZATIONS AND AGENCIES.

DMR, IN CONJUNCTION WITH THE COUNTY BOARDS, SHOULD DEVELOP METHODS TO REVIEW AND EVALUATE SERVICES AND SERVICE NEEDS. DMR SHOULD PROVIDE ADDITIONAL TRAINING AND GUIDANCE TO THE BOARDS IN DEVELOPING COMPREHENSIVE SERVICE PLANS WHICH SHOULD BE REQUIRED OF EACH BOARD.

APPENDIX

APPENDIX A

South Carolina Department of Mental Retardation

2712 Middleburg Drive
P. O. Box 4706
Columbia, South Carolina 29240

April 29, 1985

Mr. George L. Schroeder
Director
Legislative Audit Council
620 Bankers Trust Towers
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Attached is the response of the South Carolina Department of Mental Retardation to the assessment of the agency by the Legislative Audit Council.

Let me offer our appreciation to you and your staff for the cordial and cooperative working relationships in evidence during the almost eighteen months of the audit review. DMR welcomed this independent review of our overall client services and management operations. The agency has already taken action in regard to certain findings and recommendations, and we will carefully study action approaches to others. As with any audit, there are some areas in which we do not fully agree with the findings and/or recommendations. Our remarks in the attached response will cite both points of agreement and disagreement; however, failure to comment on any given points or topics should not be construed as agreement with the concept(s) offered or a lack of intent to follow-up on them.

In general, we are pleased that the audit concludes that the agency is fulfilling its legislative mandate and that virtually no major issues of client care and treatment are cited. Council staff comments to the effect that DMR has been exemplary in its cooperation during the audit are also appreciated.

Providing a balanced program of residential and community services to South Carolina's mentally retarded citizens and their families is a sizeable challenge and a rewarding professional mission. The progress in services cited in the Council's report reflects a good working partnership between

DMR's Commission, staff, providers, the members of the General Assembly, and the at-large public. Our continued efforts to provide effective client services through good stewardship of the resources provided us by the legislature will be enhanced by your organization's findings, observations, and recommendations.

With best wishes,

Cordially,

Charles D. Barnett, Ph.D.
Commissioner

CDB/rj

Attachment

DMR RESPONSE TO CERTAIN FINDINGS AND RECOMMENDATIONS
OF THE LEGISLATIVE AUDIT COUNCIL RELATIVE TO
AGENCY PROGRAMS, SERVICES, AND OPERATIONS

SECTION REFERENCE: CHAPTER II - CLIENT SERVICES

Developmental Programs - Page 13

DMR agrees with the scope and intent of the recommendations made pursuant to client habilitation plans. Changes to a specific client's programs and progress should involve an interdisciplinary team approach with program goals being assessed and revised in a timely manner.

Least Restrictive Environment - Page 19

DMR endorses the concept of least restrictive environment for each and every mentally retarded client of the agency, including children. In general, children capable of attending local school programs while enrolled in an institutional program should be assessed for community living. In fact, many children have exited DMR residential programs to return to their natural homes and attend local school programs. Further, DMR has been an active advocate and participant in efforts to overcome existing limitations and issues of responsibility relative to school children served away from their home districts. Pending legislation should resolve this issue.

Special Education Teacher's Salaries - Page 23

DMR supports the view that adequate salaries be available to recruit and retain competent staff in all service areas and disciplines, including teachers. It is noteworthy, however, that the LAC report fails to take cognizance of some 1900 direct care workers (Mental Retardation Specialists) whose starting salary is below the poverty level. Upgrading the salary structure for this critical worker group was the DMR's number one budget priority for FY 85-86.

Client Protection - Page 31

DMR agrees that its established policies and procedures for preventing and responding to suspected or alleged abuse are generally adequate. As stated, regular monthly reports of alleged or identified abuse are sent to the State Ombudsman who reviews cases on an independent basis as he determines appropriate. In selected instances DMR has asked the Ombudsman's Office to conduct an independent case review. Recently, a series of meetings with solicitors has been carried out to explore possible automatic review of abuse determinations to ensure that full prosecution under the law is provided those who mistreat clients.

All cases of alleged child abuse are also forwarded to the Department of Social Services for review and potential follow-up.

DMR believes that alleged problems with Whitten Center's timely initiation of abuse investigations have been overstated.

Suspected abuse incidents are investigated immediately by the Officer of the Day or other appropriate staff. Statements are taken and photos made as needed. Often employees are suspended. The formal investigation begins before an official investigator is appointed.

Individual abuse investigations should be conducted by personnel outside the program area within which the alleged abuse has occurred. DMR believes that its regulations around abuse investigations should be subjected to constant review and that investigators should be subject to ongoing training. We believe adequate definitions exist relative to abuse and penalties therefor.

The critical incident reporting procedure is much broader and completely separate from the abuse reporting procedure. The report's findings appear to confuse these two topics.

Referral to DSS and FCRB - Page 40

DMR believes that the criticisms of the agency for poorly planned referrals to DSS and the Foster Care Review Board are unwarranted and possibly reflect a basic lack of understanding as to in-place agreements as well as the purpose of referring clients. The Foster Care Review Board does not seek foster placements but, rather, reviews children already in temporary placements.

Regional Staff Training Programs - Page 43

DMR will review staff training requirements and methodologies. We believe that the absence of preservice and in-

service training for direct care staff prior to or during the early phases of employment is an exception and not the rule. However, no exceptions should exist in this important area. The requirement for course completion prior to promotion of direct care workers is basically in place at present. While Regional Centers should have some latitude in the design of the content and length of specific staff training courses/programs, minimum requirements and content will be reviewed. Evaluation methodologies will be reviewed and strengthened as needed.

DMR service providers who operate under contract with DMR are generally capable of training their own staff. On-call assistance from DMR is provided. Provider workshops across a range of areas are held periodically with DMR sponsorship and involvement. However, this general area will be reviewed.

SECTION REFERENCE: CHAPTER III - FINANCE AND ADMINISTRATION

Reimbursement For Educational Costs - Page 50

It is noted that the recommendation outcome for this section does not follow from the narrative - namely, that DMR continues to charge "questionable" costs to Medicaid. DMR finds no clear basis in fact or logic to support the view that client fees be used in operations versus the current legal requirement that these revenues go to debt service on capital projects or be available, with proper approvals, to directly finance construction or renovation. The account balance cited in the report is entirely budgeted for capital projects and alternate funding would be necessitated if these monies were directed to operating expenses.

The conclusion on use of client fee collections to reimburse the federal government for any audit exception around the educational costs issue is both arbitrary and premature since no final disallowance notice has been received from the Health Care Financing Administration at the time of this writing.

Management of Client Funds - Page 53

DMR's policies on the amounts allowed clients from recurring income for personal expense are both defensible and necessary to promote client well-being and development. Limiting client access to $25.00 per month is not a satisfactory practice nor is it an approach endorsed by the Social Security Administration. While Supplemental Security Income (SSI) has increased three-fold over time and inflation has risen steadily, no federal increase in the $25.00 personal allowance figure has been forthcoming. It clearly is an inadequate amount for most clients, especially those who work and earn income. It should be noted that the federal regulations state that at least $25.00 be provided to clients each month.

DMR has proposed to the State Health and Human Services Finance Commission that a proper amendment to the State Medicaid Plan be drawn so as to enable the Department to remunerate clients at the level provided for in revised AD 82-02.

Charges to Clients' Personal Accounts - Page 55

DMR believes its present policies relating to charges to clients' personal accounts to avoid the loss of Title XIX

eligibility are adequate and proper, and subject to consistent administration. While group purchases are permissible by SSA, some of the earlier "spend down" actions cited are questionable and extravagant even though State funds were not involved. It should be noted that these expenditures were at one regional center and do not typify expenditures from client funds. Further, some instances cited occurred a half decade ago.

As noted in the report, under a new administrative directive replacing AD 82-02, stricter guidelines are being established regarding the prevention of Medicaid eligibility disruption. The directive requires the adjustment of the personal needs allowance as the first priority, and the adjustment of the care and maintenance charges as the second priority in avoiding loss of Medicaid eligibility.

Also, as referenced in the report, DMR's revised administrative directive regarding financial management of client personal funds (AD 85-01) prohibits the use of an individual client's funds to purchase items for common areas, such as furniture. This directive, coupled with the revision to AD 82-02, should address the problem described.

Third Party Debt Collection - Page 60

The agency has been very aggressive in collecting third party debts. The write-off of $132,000 references payments assessed against parents prior to the time that parental pay was discontinued under South Carolina law. Many of these debts were years old. DMR has acted to have SSA designate DMR as

Representative Payee whenever it was felt that parental cooperation in this area was lacking.

Medicaid Cost Settlement - Page 64

DMR has initiated action to reduce the amount of annual Title XIX cost settlement through a modified billing method to Medicaid. Production of the cost reports in-house is under study, although the cost comparison between this strategy and the current outside contract will need analysis. In its new contract for audit services, DMR will reserve the right to produce its own cost reports in FY 87-88.

Pharmacy Operations - Page 67

Careful study of the Coastal Center pharmacy operation has already begun. Continued efforts will be directed to uniformity among the four regions in the area of pharmacy operations and accountability.

State-Owned Housing - Page 76

A Proviso in the FY '85-86 Appropriations Bill will make DMR housing at Whitten Center available to physicians and administrators without cost.

Budget Management - Page 80

DMR believes that the critical assessment of the agency's budget transfers in FY 82-83 are unwarranted, especially in a year when a mandated two million dollar budget reduction was

imposed upon the agency at or near mid-year. All budget transfers had the proper approval of the State Budget and Control Board.

Considering the two year time cycle of budget planning and implementation, it is not unexpected that an agency of DMR's size will request budget category transfers to address changing needs and opportunities. More recent initiatives of the budget process in tight money periods have invited agencies to redeploy funds from lower priority objectives to alternate needs. Paradoxically, DMR has been praised for its good management in responding to these opportunities.

DMR does not agree that inadequate regional input into the budget process exists.

DMR agrees that certain fiscal management improvements are needed and that an integrated accounting and budgeting system is a top priority. Expanded data processing capabilities are in process.

State Auditor Recommendations - Page 83

A work plan to address recommendations made by the State Auditor has been developed and is being implemented. Reorganization in key staff responsibilities and the addition of an internal audit capability are assisting this process. Considerable progress has already been accomplished.

Client Fees For Construction - Page 86

DMR finds no particular logic which successfully argues for client fees to be utilized for program operations instead of

the current legal requirement that these monies go to retire DMR capital bonds or directly fund capital improvements. The view that fees should be used to "...fund services which directly benefit the client who pays" is a serious conceptual misstatement. The state has an equal obligation to all clients in the provision of proper and adequate services, and this obligation is separate and apart from the collection of fees for services and the manner in which funds so accumulated are designated for use by the agency.

Construction of Community Residences - Page 88

DMR believes that a multiplicity of approaches to developing community houses is needed, including state construction. We concur that an expanded role for the private sector in developing houses and leasing these back to DMR providers is needed and, as noted, have been working to this end.

County MR Boards - Page 92

The DMR and its Commission are of public record in the goal to have county MR Boards - individual or multi-county - in all South Carolina counties. Boards presently operate at varying levels of complexity and responsibility. Board viability is seen as directly related to the presence of a staff and increased state investment in Boards will be necessary if they are to assume increasing levels of responsibility in the planning and service assessment areas, as well as the oversight/administration of area service programs.